FRINIED. UU/10/2018 **DEPARTMENT OF HEALTH AND HUMAN SERVICES** FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING С 495226 B. WING 06/07/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW WAYLAND NURSING AND REHABILITATION CENTER KEYSVILLE, VA 23947 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX PREFIX** (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Wayland Nursing and Rehabilitation center E 000 Initial Comments E 000 acknowledges receipt of the Statement of Deficiencies and An unannounced Emergency Preparedness survey was conducted 6/4/19 through 6/7/19. proposes this Plan of Corrections are required for compliance with 42 Correction to the extent that CFR Part 483.73, Requirement for Long-Term the summary of findings is Care Facilities. One complaint was investigated factually correct and in order during the survey. E 036 EP Training and Testing E 036 to maintain compliance with SS=D CFR(s): 483.73(d) the applicable rules and provisions of quality of care of (d) Training and testing. The [facility] must residents. This Plan of develop and maintain an emergency preparedness training and testing program that is Correction is submitted as a based on the emergency plan set forth in written allegation of paragraph (a) of this section, risk assessment at compliance. paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and Wayland Nursing and the communication plan at paragraph (c) of this section. The training and testing program must Rehabilitation Center's be reviewed and updated at least annually. response to this Statement of Deficiencies does not denote *[For ICF/IIDs at §483.475(d):] Training and agreement with the testing. The ICF/IID must develop and maintain an emergency preparedness training and testing Statement of Deficiencies nor program that is based on the emergency plan set does it constitute an forth in paragraph (a) of this section, risk admission that any deficiency assessment at paragraph (a)(1) of this section. policies and procedures at paragraph (b) of this is accurate. Wayland Nursing section, and the communication plan at and Rehabilitation Center paragraph (c) of this section. The training and reserves the right to refute testing program must be reviewed and updated at any of the deficiencies on this least annually. The ICF/IID must meet the requirements for evacuation drills and training at Statement of Deficiencies §483.470(h). through Informal Dispute Resolution, formal appeal *[For ESRD Facilities at §494.62(d):] Training, procedure and/or any other . testing, and orientation. The dialysis facility must develop and maintain an emergency administrative or legal proceeding. ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE (X8) DATE

uny deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days ollowing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 lays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

ORM CMS-2567(02-99) Previous Versions Obsolete

Electronically Signed

Event ID: 54S511

Facility ID: VA0050

FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING C 06/07/2019 495226 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 730 LUNENBURG HIGHW WAYLAND NURSING AND REHABILITATION CENTER KEYSVILLE, VA 23947 PROVIDER'S PLAN OF CORRECTION (X5)SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID COMPLETION (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) E 036 E 036 Continued From page 1 E-36 preparedness training, testing and patient The emergency Preparedness orientation program that is based on the emergency plan set forth in paragraph (a) of this Plan was updated and section, risk assessment at paragraph (a)(1) of completed to include training this section, policies and procedures at paragraph and testing and was reviewed (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and approved. and orientation program must be reviewed and Staff will maintain evidence of updated at least annually. This REQUIREMENT is not met as evidenced testing in a log book and the by: log will be updated as Based on staff interview and facility document review it was determined that the facility staff necessary. failed to have a complete emergency Evidence of training and preparedness plan. testing of the EP will be The facility staff failed to evidence documentation submitted to the Safety that the facility has a written training and testing Committee of the facility for program that meets the requirements of the compliance and proper regulation and documentation that the training and testing program has been reviewed and documentation. updated on, at least an annual basis. Minutes of the Safety The findings include: Committee will be submitted to the facility's QAPI An interview was conducted with ASM committee for review and (administrative staff member) #1, the administrator, regarding the emergency suggestions. preparedness plan, specifically about the training and testing program and review of the program and any updates completed on an annual basis. ASM #1 informed this surveyor that they did not have documentation that the training and testing program has been reviewed and updated on an

annual basis.

ASM #1, the administrator, ASM #2, the director of nursing, and ASM #4, the facility nurse consultant, were made aware of the above

PRINTED: 06/18/2019

		ID HUMAN SERVICES MEDICAID SERVICES			FORM APPROMB NO. 0938-	OVED
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495226	B. WING		C 06/07/201 <u>9</u>	9
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
WAYLAND	NURSING AND REHAB	ILITATION CENTER		730 LUNENBURG HIGHW KEYSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		ETION
E 036	Continued From page	2	E 036	3		
	concerns on 6/6/19 at	7:35 p.m.	40)		l	
E 037	EP Training Program		E 037	' E-37		
SS=C	CFR(s): 483.73(d)(1)					
				Staff will receive training and	, l	
		The [facility, except CAHs,		instructions on the facility's		
		ations, PRTFs, Hospices,		Emergency preparedness		
	and dialysis lacililles)	must do all of the following:		training. Documentation of		
	(i) Initial training in em	nergency preparedness		new hires initial training will		
101		es to all new and existing				
	staff, individuals provi	_		be kept in the SDC office.		
		unteers, consistent with their		The administrator or his		
	expected role.				al le	
		y preparedness training at		designee will conduct annua		
	least annually.	Ankley of the Aveleton		training sessions with staff t	.0	
	(iii) Maintain documer	itation of the training. Knowledge of emergency		educate them on the		
	procedures.	Knowledge of emergency		Emergency Plan and any		
		2.15(d) and RHCs/FQHCs		updates that may have		
		ng program. The [Hospital		occurred.		
	or RHC/FQHC] must					
	(i) Initial training in em	nergency preparedness		Proof of annual in-service		
		es to all new and existing		training on the EP will be ke	≥pt	
		ding on-site services under		in the SDC office and		
	expected roles.	unteers, consistent with their		Submitted to the facility	90	
	•	y preparedness training at		Safety Committee for review	ew	
	least annually.	y preparedness training at		and compliance.		
	(iii) Maintain documer	ntation of the training.		and compliance.		
		knowledge of emergency		The meetings of the Safet	/	
	procedures.	- · ·		committee as well as proc		,
				annual and initial in-service	e 1.	10
		8.113(d):] (1) Training. The			e //2/	117
	hospice must do all of			training on the EP will be	11	1. 1
		nergency preparedness es to all new and existing		submitted to the QAPI	_	
		es to all new and existing and individuals providing		Committee for review and		
		lement, consistent with their		compliance.		

AND DI AN OF CODDECTION			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
NAME OF P	ROVIDER OR SUPPLIER	495226	B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE	06/C)7/201 <u>9</u>
WAYLANI	NURSING AND REHAB	LITATION CENTER		730 LUNENBURG HIGHW KEYSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
E 037	procedures. (iii) Provide emergency least annually. (iv) Periodically review emergency preparedry employees (including special emphasis place procedures necessary others. *[For PRTFs at §441.* program. The PRTF in (i) Initial training in empolicies and procedure staff, individuals proviarrangement, and voluexpected roles. (ii) After initial training preparedness training (iii) Demonstrate staff procedures. (iv) Maintain documer preparedness training in empolicies and procedures of i) Initial training in empolicies and procedures and procedures and procedures taff, individuals proviarrangement, contract volunteers, consistent (ii) Provide emergency least annually. (iii) Demonstrate staff procedures, including	knowledge of emergency by preparedness training at a and rehearse its less plan with hospice nonemployee staff), with led on carrying out the a to protect patients and 184(d):] (1) Training must do all of the following: lergency preparedness les to all new and existing ding services under unteers, consistent with their a provide emergency at least annually. knowledge of emergency attation of all emergency	E 03			

	F CORRECTION	IDENTIFICATION NUMBER:		CONSTRUCTION	COMPLETED
		495226	B. WING		C 06/07/2019
	ROVIDER OR SUPPLIER NURSING AND REHAB	LITATION CENTER	1 73	TREET ADDRESS, CITY, STATE, ZIP CODE 80 LUNENBURG HIGHW EYSVILLE, VA 23947	3310112013
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
E 037	case of an emergency (iv) Maintain documer *[For CORFs at §485. CORF must do all of to (i) Provide initial training preparedness policies and existing staff, indiffunder arrangement, a with their expected role (ii) Provide emergency least annually. (iii) Maintain document (iv) Demonstrate staff procedures. All new pand assigned specific the CORF's emergency their first workday. The include instruction in the alarm systems and signed equipment. *[For CAHs at §485.62] The CAH must do all of (i) Initial training in empolicies and procedure reporting and extinguis and where necessary, personnel, and guests cooperation with firefig authorities, to all new individuals providing sand volunteers, consist roles. (ii) Provide emergency least annually. (iii) Maintain document	Atation of all training. 68(d):](1) Training. The he following: Ing in emergency and procedures to all new viduals providing services and volunteers, consistent es. If preparedness training at the tation of the training. It knowledge of emergency ersonnel must be oriented responsibilities regarding by plan within 2 weeks of extraining program must he location and use of grain and firefighting. 125(d):](1) Training program. 13 If the following: 14 ergency preparedness es, including prompt shing of fires, protection, evacuation of patients, fire prevention, and ghting and disaster and existing staff, ervices under arrangement, stent with their expected.	E 037		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495226	B. WING_			C /07/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
WAYLAND	NURSING AND REHAB	LITATION CENTER	1	730 LUNENBURG HIGHW		
				KEYSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION ((EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO T	BE	(X5) COMPLETION DATE
E 037	CMHC must provide in preparedness policies and existing staff, indi under arrangement, a with their expected rol documentation of the demonstrate staff kno procedures. Thereafte emergency preparednannually. This REQUIREMENT by: Based on staff intervireview it was determing failed to have a complipreparedness plan. The facility staff failed of the facility's initial e training and annual ertraining offerings and staff have received inipreparedness training. The findings include: An interview was condudinistrative staff madministrator on 6/6/1 asked for the facility's preparedness training preparedness training documentation that fa	.920(d):] (1) Training. The nitial training in emergency and procedures to all new viduals providing services and volunteers, consistent les, and maintain training. The CMHC must wiedge of emergency er, the CMHC must provide less training at least is not met as evidenced ew and facility document led that the facility staff lete emergency reparedness mergency preparedness documentation that facility tial & annual emergency . ducted with ASM lember) #1, the 9 at 6:47 p.m. ASM #1 was initial emergency and annual emergency offerings and cility staff have received ency preparedness training.	E			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495226	B. WING			C 07/2019
	ROVIDER OR SUPPLIER NURSING AND REHAB		7	STREET ADDRESS, CITY, STATE, ZIP CODE 30 LUNENBURG HIGHW (EYSVILLE, VA 23947		0772013
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
E 037	preparedness training get the information in training has not been	initial emergency and the annual emergency . He stated the employees orientation but the annual completed. rator, ASM #2, the director #4, the facility nurse e aware of the above	E 037			
	An unannounced Med survey was conducted 6/7/19. Complaints w survey. Corrections a with the following 42 C Long Term Care requi code survey/report will The census at this 90 at the time of the survey.	ere investigated during this re required for compliance CFR Part 483 of the Federal rements. The life safety				
F 550 SS=D	self-determination, an access to persons and outside the facility, inciting this section. §483.10(a)(1) A facility with respect and dignity resident in a manner at	2)(b)(1)(2) Rights. ht to a dignified existence, d communication with and d services inside and cluding those specified in y must treat each resident	F 550			

FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING_ С B. WING 495226 06/07/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW WAYLAND NURSING AND REHABILITATION CENTER KEYSVILLE, VA 23947 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE PRFFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG **DEFICIENCY**) F-550 F 550 Continued From page 7 F 550 her quality of life, recognizing each resident's Resident #10's catheter bag individuality. The facility must protect and was emptied of urine and promote the rights of the resident. properly covered to ensure §483.10(a)(2) The facility must provide equal privacy and dignity. access to quality care regardless of diagnosis, severity of condition, or payment source. A facility An inspection of other must establish and maintain identical policies and residents with indwelling practices regarding transfer, discharge, and the catheters was conducted and provision of services under the State plan for all residents regardless of payment source. there were no other issues found. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her Nursing staff will be rights as a resident of the facility and as a citizen responsible for maintain or resident of the United States. privacy bags on residents with §483.10(b)(1) The facility must ensure that the indwelling catheters. The RN resident can exercise his or her rights without Charge nurse will report any interference, coercion, discrimination, or reprisal non-compliance with catheter from the facility. bags to the Cardinal IDT §483.10(b)(2) The resident has the right to be members at their morning free of interference, coercion, discrimination, and and/or evening meeting. Nonreprisal from the facility in exercising his or her compliance will be corrected rights and to be supported by the facility in the exercise of his or her rights as required under this immediately. subpart. This REQUIREMENT is not met as evidenced Results of the Cardinal IDT by: meetings Catheter log will be Based on observation, staff interview, clinical reviewed weekly to ensure record review, and facility document review, it compliance. The logs will be was determined the facility staff failed to ensure and promote dignity for one of 33 residents in the reviewed by the QAPI survey sample, Resident #10. Resident #10's committee at its monthly indwelling urinary catheter (1) collection bag was meeting. uncovered with urine in the bag during multiple

observations.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	CONSTRUCTION	COMPLETED	
		,,,,,		С	
	495226 ROVIDER OR SUPPLIER D NURSING AND REHABILITATION CENTER	STF 730	REET ADDRESS, CITY, STATE, ZIP CODE LUNENBURG HIGHW YSVILLE, VA 23947	06/07/201 <u>9</u>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)		
F 550	Continued From page 8 The findings include: Resident #10 was admitted to the facility on 2/21/19 with the diagnoses of but not limited to high blood pressure, chronic obstructive pulmonary disease (2), obstructive and reflux uropathy (3), benign prostatic hyperplasia with lower urinary tract symptoms, and retention of	F 550	8		
	urine. The most recent MDS (Minimum Data Set), a Significant Change in Status Medicare assessment, with an ARD (Assessment reference date) of 3/18/19, coded the resident as scoring a 9 out of 15 on the BIMS (Brief Interview for Mental Status) score, indicating the resident had moderate cognitive impairment for daily decision making. The resident was coded as having an indwelling urinary catheter.				
	On 6/4/19 at 3:12 p.m., 4:20 p.m., and 5:18 p.m., Resident #10's indwelling urinary catheter collection bag was observed uncovered, exposed, and hanging on the bed frame. During each observation, urine was observed in the bag. On 6/5/19 at 8:19 a.m., Resident #10's indwelling urinary catheter collection bag was observed uncovered, exposed, and hanging on the bed frame. During this observation, urine was	4			
	observed in the bag. On 6/6/19 at 12:43 p.m., an interview was conducted with LPN (Licensed Practical Nurse) #3. LPN #3 was asked about the process staff follow in regards to a resident Foley collection bag. LPN #3 stated, "It needs to be covered for privacy." LPN #3 was asked if it was acceptable for a Foley collection bag to be uncovered. LPN #3 stated "Yes. It is a dignity issue. The Hospice				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495226	B. WING		06/0	07/2019
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
WAYLAND	NURSING AND REHAB	ILITATION CENTER	11	730 LUNENBURG HIGHW		
				KEYSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 550	they have covers. It v Tuesday." When ask Foley collection bag of have to talk with some On 6/7/19 at 11:48a.n Staff Member) #1, the aware of the findings.	s Foley and I don't think	F 55		ě	
	body. This information website: https://medlineplus.go. 00140.htm (2) Chronic obstructive Disease that makes it lead to shortness of bottained from the web https://www.nlm.nih.go.	n was obtained from the ov/ency/patientinstructions/0 e pulmonary disease: difficult to breath that can reath. This information was				
F 559 SS=D	uropathy is a condition is blocked. This cause injure one or both kidrobtained from the web https://medlineplus.go Choose/Be Notified of CFR(s): 483.10(e)(4)-§483.10(e)(4) The rigid or her spouse when making facility and both arrangement.	n in which the flow of urine es the urine to back up and neys. This information was osite: ov/ency/article/000507.htm f Room/Roommate Change	F 55	9		

FINITED. 00/10/2018 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA F CORRECTION IDENTIFICATION NUMBER:	(X2) MULTIPLE C	CONSTRUCTION	COMPLETED
		1.4. 001001140		Ç
	495226	B. WING		06/07/2019
NAME OF P	ROVIDER OR SUPPLIER	ST	REET ADDRESS, CITY, STATE, ZIP CODE	
MANUA A SIP	NURSING AND REHABILITATION CENTER	730	0 LUNENBURG HIGHW	
WATLAND	NORTHE AND REPABLISHION CENTER	KE	EYSVILLE, VA 23947	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD)	(X5) RF COMPLETION
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	DATE
			F-559	
F 559	Continued From page 10	F 559	Desident #22 and her resident	
	or her roommate of choice when practicable,		Resident #33 and her resident	
ě.	when both residents live in the same facility and		representative were provided	
	both residents consent to the arrangement.		written explanation as to the	
	§483.10(e)(6) The right to receive written notice,		reason for moving to another	
	including the reason for the change, before the		room within the facility.	
	resident's room or roommate in the facility is		No other resident in the	
	changed. This REQUIREMENT is not met as evidenced		facility was identified as not	
	by:		being notified.	
	Based on staff interview, facility document		_	
	review, and clinical record review, it was		Approvals for a room move	
	determined the facility staff falled to provide notice to the resident and/or responsible		will be discussed in the	
	representative for a room change for one of 33		morning Cardinal IDT meeting	
	residents in the survey sample, Resident #33.		before a room move is done.	
			The administrator or his	
	The facility staff failed to provide the resident and		designee will ensure that the	
	or resident representative with a written notification/explanation of why a move was		Social Worker properly	
	required for Resident #33, prior to a room change		notifies residents and their RR	
	from the skilled unit to the long-term care unit,		as to the reason for a room	
	and failed to provide an opportunity for the		move and that the resident	
	resident to view the room prior to the move.		has viewed the room and met	
	The findings include:		any new roommate. Copies of	
			the written notification will be	
	Resident #33 was admitted to the facility on		kept in the Social services	
	5/1/19 with diagnoses that included but were not			
	limited to: dementia, high blood pressure,		Office.	
	diabetes, stroke and COPD (chronic obstructive		Room moves will be	
	pulmonary disease - general term for chronic, nonreversible lung disease that is usually a		completed and reported back	
	combination of emphysema and chronic		to the Cardinal IDT members	
	bronchitis) (1).			1 .\19
			to verify that proper	417///
	The most recent MDS (minimum data set)		documentation and	, • • • • • • • • • • • • • • • • •
	assessment, an admission assessment, with an		notifications were completed.	
	assessment reference date of 5/8/19, coded the		_ Room moves will be	<u> </u>
ORM CMS-256	37(02-99) Previous Versions Obsolete Event ID: 54S511	l Fac	monitored weekly by the	ation sheet Page 11 of 169

cardinal IDT members and submitted to the facility QAPI committee for oversight.

	F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED		
		495226	B. WING		C 06/07/2019		
	ROVIDER OR SUPPLIER NURSING AND REHA	BILITATION CENTER	730 1	EET ADDRESS, CITY, STATE, ZIP CODE LUNENBURG HIGHW SVILLE, VA 23947	00/01/2010		
(X4) ID PREFIX TAG	(EACH DEFICIENT	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION		
F 559	interview for mental is severely impaired decisions. The resident extensive assistance one staff member for living. The resident was ob-	e 11 a "3" on the BIMS (brief status) score, indication she to make daily cognitive ent was coded as requiring to being dependent upon all of her activities of daily served to be in a room on the n 6/4/19. Review of the	F 559				
	clinical record reveal previously on the reference. The resident we care in the facility on The nurse's note data documented, "Res. (XXX A bed, adjusting no problems noted. I Further review of the evidence any documented to being shown	ed the resident was abilitation hall for respite as transferred to long-term					
	staff member (ASM) 6/5/19 at 4:36 p.m. V #33 was moved from the long term care have resident goes to the All-inclusive Care for Tuesday and Thursd just for respite care the for at home. She was care through PACE. rooms was not a man felt that she could be the days she goes of	aducted with administrative #1, the administrator, on When asked why Resident to the rehabilitation hallway to allway, ASM #1 stated the PACE (Program of the Elderly) program every ay. She was originally here but could no longer be cared as transferred to long-term The reason she was moved tter of convenience, it was a closer to the front door for ut to PACE. She would have bobby for an extended period.					

	CORRECTION	IDENTIFICATION NUMBER:		G	(,,3	COMPLETED
		405226	B WING			C
	ROVIDER OR SUPPLIER D NURSING AND REHAE	495226 BILITATION CENTER	B. WING	STREET ADDRESS, CITY, ST 730 LUNENBURG HIGHW KEYSVILLE, VA 23947	 TATE, ZIP CODE	06/07/201 <u>9</u>
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTION CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 559	This way she was my front door and can be wished for pick up by An interview was commember (OSM) #4, that 4:07 p.m. When as change is made in the stated, "I call both the (RR) and talk to the interview the computer under inchange in the clinical resident and/or family regarding the room of I just call them and done and the roommate, OSM OSM #4 reviewed the clinical record and stowriting a note." When transferred rooms, OM when resident have a stated, "The request A RR can request a notify the roommate roommate. We need When asked if they get a stated of the process of t	by ed and is closer to the estiting in her room if she PACE driver. Inducted with other staff the social worker, on 6/5/19 sked the process when a re resident's room, OSM #4 resident representative resident. Then I document in room change or roommate I record." When asked if the y is given anything in writing thange, OSM #4 stated, "No, ocument it." When asked if RR was shown the room and the opportunity to meet #4 stated, "I don't think so." re notes in the computerized ated, "I don't remember	F 5		SEPTOLENCY)	20
	regarding the room of the resident's reques When asked if the re room, ASM #1 stated	thange, ASM #1 stated, "if it's st, I don't believe it is done." sident is shown the new i, "Yes, of course." When all documented, ASM #1				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	!	M				
		495226	B. WING		06/	07/2019
NAME OF P	ROVIDER OR SUPPLIER		8	TREET ADDRESS, CITY, STATE, ZIP CODE		
WAYI AND	NURSING AND REHAB	ILITATION CENTER		30 LUNENBURG HIGHW		
TIATEAN	- TORONO AND REHAD	ELIATION GENTER	ŀ	CEYSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 559	Changes" documente assigned to residents medical and social ne sourceThe resident representative or an informed before the reis changed. Timely no resident and the famil rooms or when a resident and the famil rooms or when a resident and will monit change and will monit new room and roomm. ASM #1, the administ facility nurse consulta above findings on 6/6	com Assignments/Room d in part, "Rooms are in accordance with their leds, and their payment and the resident's legal interested family member is lesident's room or roommate lotice should be given to the ly when a resident changes dent received a new and after any room change, prepare the resident for the lor the adjustment to the late."	F 559			
F 622 SS=E	Non-Medical Reader, Chapman, page 124. Transfer and Dischard CFR(s): 483.15(c)(1)(s)483.15(c)(1) Facility (i) The facility must peremain in the facility, discharge the resident (A) The transfer or disresident's welfare and cannot be met in the (B) The transfer or disbecause the resident's	i)(ii)(2)(i)-(iii) and discharge- requirements- ermit each resident to and not transfer or at from the facility unless- scharge is necessary for the at the resident's needs	F 622			

/ED 391

	·	ID HUMAN SERVICES MEDICAID SERVICES				FORM OMB NO	APPROV . 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE : COMPI	LETED
		495226	B. WING				。 07/2019
	ROVIDER OR SUPPLIER NURSING AND REHAE			ST 73	REET ADDRESS, CITY, STATE, ZIP CODE 0 LUNENBURG HIGHW EYSVILLE, VA 23947		
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI	3E	(X5) COMPLETIO DATE
F 622	services provided by (C) The safety of indicendangered due to the status of the resident (D) The health of indicendangered due to the status of the resident (D) The health of indicendant of the resident has appropriate notice, to under Medicare or Medicare (F) The facility cease (ii) The facility cease (iii) The facility may not resident while the aps 431.230 of this charge notice from 431.220(a)(3) of this discharge or transfer or safety of the resident into the facility. The facility resident into the resident of the resident into the safety of the safety	the facility; viduals in the facility is ne clinical or behavioral ; viduals in the facility would ered; failed, after reasonable and pay for (or to have paid edicaid) a stay at the facility. if the resident does not v paperwork for third party third party, including d, denies the claim and the ay for his or her stay. For a es eligible for Medicaid after v, the facility may charge a sle charges under Medicaid;	F 63	22	Physician documentation for transfer was obtained for resident #s 41, 22, 25, 13, 15, 43, 49, 46 and 19. A copy of the resident's care plan for each affected resident was sent to the receiving hospital. A review of discharges for the last 30 days was conducted and no other issues were found. The medical director will be in-serviced on the necessary documentation required for transfers. Nursing staff will be in-serviced on the necessity to include the resident's comprehensive care plan goals. Unplanned discharges will be reviewed by the Cardinal IDT members at its morning meeting to ensure that all		

FORM CMS-2567(02-99) Previous Versions Obsolete

§483.15(c)(2) Documentation.

When the facility transfers or discharges a resident under any of the circumstances specified

in paragraphs (c)(1)(i)(A) through (F) of this

or discharge is documented in the resident's medical record and appropriate information is

communicated to the receiving health care

section, the facility must ensure that the transfer

Event ID: 54S511

Results of the Unplanned Facilit Discharges log will be submitted to the QAPI Committee at its monthly meeting for oversight and direction.

documentation and transfer

papers are sent. An audit tool

of unplanned discharges will

be kept by the team and

reviewed weekly for

compliance.

ontinuation sheet Page 15 of 169

	C 6/07/201 <u>9</u>
	6/07/2019
NAME OF PROVIDED OR OURSELD	-
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
730 LUNENBURG HIGHW	
WAYLAND NURSING AND REHABILITATION CENTER KEYSVILLE, VA 23947	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 622 Continued From page 15 institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1) (i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c) (2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c)(1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with \$483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, the facility staff failed to evidence that the required physician documentation was completed and/or the	

	F CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COMPLETED
	495226 ROVIDER OR SUPPLIER D NURSING AND REHABILITATION CENTER	st 73	REET ADDRESS, CITY, STATE, ZIP CODE 10 LUNENBURG HIGHW EYSVILLE, VA 23947	C 06/07/201 <u>9</u>
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	5.55
F 622	Continued From page 16 required transfer documentation was provided to a receiving facility for facility initiated hospital transfers for nine of 33 sampled residents, Residents #41, #22, #25, #13, #15, #43, #49, #46, and #19. The findings include:	F 622	51	
	1. The facility staff failed to evidence the required physician documentation was completed and evidence what, if any, required transfer documentation was provided to the receiving facility when Resident #41 was transferred to the hospital on 4/16/19.			
	Resident #41 was admitted to the facility on 7/10/18 with the diagnoses of but not limited to, acute respiratory failure, diabetes, high blood pressure, anxiety disorder, breast cancer, bladder disorder, atrial fibrillation, congestive heart failure, chronic obstructive pulmonary disease, and osteoporosis. The most recent MDS (Minimum Data Set) was a significant change assessment with an ARD (Assessment Reference Date) of 5/3/19. The resident was coded as being moderately impaired in ability to make daily life decisions.			
9	A review of the clinical record revealed the following nurses note: 4/16/19 at 3:39 PM: "Therapy alerted writer that resident was c/o (complaining of) stabbing pain in left arm and o2 [oxygen] sats [saturations] were in the 80's on O2 @ (at) 3L/M (three liters per minute). Writer in to assess resident. Resident continues to c/o sharp pain in left arm, non-radiating. C/o SOB (shortness of breath). O2 sats 90% on O2@3L/M. Resident slow to respond to writers questions. Speech slurred at times. B/P (blood			

	OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		COMPLETED
	495226	B. WING		C
	NURSING AND REHABILITATION CENTER	STR 730	EET ADDRESS, CITY, STATE, ZIP CODE LUNENBURG HIGHW /SVILLE, VA 23947	06/07/201 <u>9</u>
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 622	Continued From page 17 pressure) 130/64, HR (heart rate) 134, RR (respiratory rate) 22. (Name of Nurse Practitioner) made aware and orders received to send to ER (emergency room) for further evaluation. Bed hold policy placed in paperwork and sent with resident. Resident is her own RR (responsible representative) and aware." Further review of the clinical record failed to reveal any evidence of what, if any, required documentation was provided to the receiving facility. There was no evidence that the required physician documentation (what efforts the facility attempted to prevent the need for hospitalization, why the facility was not able to meet the resident's needs, and what specific services the hospital could provide for the resident that the facility could not) was completed. An interview was conducted with LPN (licensed practical nurse) #5 on 6/5/19 at 2:37 p.m., regarding the paper work the facility sends with a resident being transferred to the hospital. LPN #5 stated, "The DNR [do not resuscitate] form, immunization record, bed hold policy, copy of the med (medication) list, copy of the order to send to the ER [emergency room]." When asked where staff documents what was sent to the hospital, LPN #5 stated, "We don't always document that we send all of that. We do write a note about the bed hold." When asked if the comprehensive care plan goals are sent with residents, LPN #5 stated, "No, I don't usually. We send the transfer form that has if they are continent or incontinent, the reason they are going to the ER, their insurance information, vital signs and the contact information for the resident representative." When asked if the doctor or nurse practitioner	F 622		
	stated, "No, I don't usually. We send the transfer form that has if they are continent or incontinent, the reason they are going to the ER, their insurance information, vital signs and the contact information for the resident representative."			X

	CORRECTION CONTROL IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED
	405226	B. WING		C
	495226 ROVIDER OR SUPPLIER DINURSING AND REHABILITATION CENTER	STRE	EET ADDRESS, CITY, STATE, ZIP CODE LUNENBURG HIGHW 'SVILLE, VA 23947	06/07/201 <u>9</u>
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 622	Continued From page 18 hospital, LPN #5 stated, "Sometimes when the resident comes back they will document why they were sent to the hospital." On 6/06/19 at 7:08 p.m., in an interview with LPN	F 622		
4	#4, she stated that when a resident is sent to the hospital, the facesheet, code status, current MAR (Medication Administration Record) and bed hold policy are sent. She stated that the facility does not use a transfer form; that the care plan goals are not sent; and that she did not know what the requirements for physician documentation were. When asked how the facility evidences that all the required documentation was provided to the hospital, LPN #4 stated, "Unless you put it in a note, which we don't really, there isn't a way to know what was sent."			
	An interview was conducted with ASM (administrative staff member) #2,, the director of nursing, on 6/5/19 at 2:47 p.m., regarding what documentation the facility provide to the receiving hospital for residents that are transferred. ASM #2 stated, "Face sheet, med [medication] list, DNR [do not resuscitate], order to send to the ER [emergency room], bed hold policy, immunization, lab (laboratory) or x-ray results. I then call 911,			
	call the hospital with report." When asked if the staff send the comprehensive care plan goals, ASM #2 stated, "No, we do not." When asked if the doctor's write a note of why the resident went to the hospital, ASM #2 stated, "Sometimes."			
	A review of the facility policy, "Transfer and Discharge" documented, "The facility will permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless: a) The transfer or discharge is necessary for the resident's welfare and the resident's needs			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
				21 =	(
		495226	B. WING		06/	07/2019
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
WAVE AND NUDSING AND DELIABILITATION CENTED			1 7	30 LUNENBURG HIGHW		
WAYLAND NURSING AND REHABILITATION CENTER			K	KEYSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 622	have documentation in record that the above The resident's attendid documentation that sit "b" have occurredB discharges a resident, resident and, if known representative of the the reasons for the molanguage and manner the reason(s) in the reason(s) in the reason for the molanguage and manner the reason(s) in the reason for the molanguage and manner the reason(s) in the reason for the molanguage and manner the reason for the molanguage and manner the reason for the molanguage and manner the reason for the policy did not include required components documentation of a hold commentation of the Omlof a written bed hold pure of the Malanguage and manner the reason for the policy did not include a written bed hold pure of the Omlof a written bed hold pure of the Omlof a written bed hold pure of the Malanguage and manner the reason for the reason for the Malanguage and manner the reason for the reason for the Malanguage and manner the reason for the reason for the residuation of the Omlof a written bed hold pure of the Malanguage and manner the reason for t	racility;The facility will in the resident's medical situations have occurred. In physician will provide tuations discussed in "a" or efore a facility transfers or in the facility will: *Notify the in, a family member or legal transfer or discharge and tove in writing and in a they understand. *Record resident's clinical record." ude any criteria for the of the physician respital transfer; the specific sust be provided to the a hospital transfer; written resudsman, or the provision respital transfer or the resudsman or the provision respital transfer or the resudsman or the provision respital transfer or the resudsman or the provision respital transfer or the provision or the provision respital transfer or the transfer or the provision o	F 622			6
	and reduce fever. Information obtained f	o treat mild to moderate pain from ov/druginfo/meds/a681004.h	9	15		
	physician documentat	led to evidence the required ion was completed and ired transfer documentation eceiving facility when		20		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		40-000	B 147110			С	
		495226	B. WING			5/07/201 <u>9</u>	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	P CODE		
WAYLAND	NURSING AND REHA	BILITATION CENTER	1	730 LUNENBURG HIGHW			
				KEYSVILLE, VA 23947			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE	
F 622	Continued From pag	ge 20	F 6	22			
	Resident #22 was tr 3/11/19 and 4/29/19	ansferred to the hospital on					
	11/23/12 with the dia dementia, atrial fibril kidney disease, Alzh psychotic disorder. (Minimum Data Set) with an ARD (Asses 6/3/19. The residen	dmitted to the facility on agnoses of but not limited to lation, diabetes, chronic seimer's disease, and The most recent MDS was an annual assessment sment Reference Date) of t was coded as being impaired in ability to make			5		
	note dated 3/11/19 a Resident #22 was so from the wheelchair documented in part, notified and gave or (emergency room) fo RR (resident represe Resident left facility rescue squad)." A no	al record revealed a nurse's at 9:15 a.m., that documented ent to the hospital after a fall for evaluation. The note "NP (nurse practitioner) was der to send to ER or eval (evaluation) and treat. entative) made aware. at 0900 (9:00 AM) via (county urse's note dated 3/11/19 at ed, "Copy of bed hold policy					
	"SNF/NF to Hospital documented the resinformation, code star Precautions, Skin/Winformation, Rehabil for transfer, Key Clin status, where the respessentative information of the respession of the results of the result	atus, Risk Alerts, Isolation ound Care, facility contact itation Therapy status, reason ical Information, functional sident was sent to, resident nation, and mental status. hented evidence of the s and medications being					

		ND HUMAN SERVICES				D: 06/18/2019 MAPPROVED
		MEDICAID SERVICES				0. 0938-0391
	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	· ·	PLETED
		495226	B. WING		06/0	
NAME OF P	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	06/0	07/201 <u>9</u>
WAYLANI	D NURSING AND REHAB	OII ITATION CENTED		730 LUNENBURG HIGHW		
WAI =) NORGING AND INDIAD	ALITATION GENTER		KEYSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 622	Continued From page	e 21	F 622	-		
,	RespiratoryDietN	Medications" were all left			1	
	blank. There was no	evidence that a copy of the ration Record and Treatment		~		
		d (MAR and TAR) were				
	provided. There was	no evidence that the				
	comprehensive care paddition, this form wa	plan goals were provided. In as dated 3/11/19 and the				
		ns dated 3/11/19 and the				
	however, the form doo	cumented that the date of				
	transfer was 9/11/18.					
	Further review also fa	ailed to reveal any evidence				
	that the required phys	sician documentation (what	1			
	efforts the facility after for hospitalization, wh	mpted to prevent the need by the facility was not able to	1			
	meet the resident's ne	eeds, and what specific		€		
1	services the hospital of	could provide for the				
	resident that the facilit completed.	y could not) was				
	Further review of the	clinical record revealed a			()	
	nurse's note dated, 4/2	/29/19 at 1:32 p.m., that				
	documented the reside	lent was sent to the hospital				
[]	for evaluation. The no	ote documented in part the ed NP (nurse practitioner)				
	a0915 (sic) (at 9:15 a.i	.m.) and was given an order				
1	to send to ER (emerge	ency room). 0920 (9:20		1		
	AM) (county) rescue no message for RR (residual)	notified. 0925 (9:25 AM) left dent representative) to call				
1	facility. 0940 (9:40 AM	M) Rescue squad arrived.		1		
(0945 (9:45 AM) Reside	lent left facility via stretcher				
:	and 2 attendants. Atte	empted to call report to ER (12:40 PM) RR (resident		ĺ		
r	representative) made a	aware of above."				
		clinical record revealed an				

"SNF/NF to Hospital Transfer Form" dated 4/29/19. The form documented the resident's PRINTED: 06/18/2019

PRINTED: 06/18/2019 DEPARTMENT OF HEALTH AND HUMAN SERVICES **FORM APPROVED** CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING C 495226 B. WING 06/07/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW WAYLAND NURSING AND REHABILITATION CENTER **KEYSVILLE. VA 23947** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION **PREFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Continued From page 22 F 622 demographic information, code status. Risk Alerts, Isolation Precautions, Skin/Wound Care, facility contact information. It also documented Rehabilitation Therapy status, reason for transfer, Key Clinical Information, functional status, where the resident was sent to, and resident representative information. There was no documented evidence of the resident's treatments and medications being provided. The area titled, "Treatments: Respiratory....Diet....Medications...." were all left blank. There was no evidence that a copy of the Medication Administration Record and Treatment Administration Record (MAR and TAR) were provided. There was no evidence that the comprehensive care plan goals were provided. An interview was conducted with ASM (administrative staff member) #2,, the director of nursing, on 6/5/19 at 2:47 p.m., regarding what documentation the facility provide to the receiving hospital for residents that are transferred. ASM #2 stated, "Face sheet, med [medication] list. DNR [do not resuscitate], order to send to the ER [emergency room], bed hold policy, immunization,

form.

lab (laboratory) or x-ray results. I then call 911, call the hospital with report." When asked if the staff send the comprehensive care plan goals, ASM #2 stated, "No, we do not." When asked if the doctor's write a note of why the resident went to the hospital, ASM #2 stated, "Sometimes."

On 6/6/19 at 7:43 PM, ASM #1 (the

Administrator), ASM #2 and ASM #4 (Facility Nurse Consultant) were notified of the concerns. ASM #1 inquired about a transfer form for the required transfer information and ASM #2 then stated that the facility does not use a transfer

		ND HUMAN SERVICES					D: 06/18/2019 MAPPROVED
		MEDICAID SERVICES		_		OMB N	O. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
		495226	B. WING				C /07/2019
NAME OF P	ROVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, STATE, ZIP CODE	. 00	10112019
WAYLAND NURSING AND REHABILITATION CENTER			7	30 LUNENBURG HIGHW			
	TOTAL TALLACT			K	KEYSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 622	Continued From page	23	F	622			
		ž.					
	3. The facility staff fai required documentation receiving facility when transferred to the hos	led to evidence what, if any on was provided to the Resident #25 was oital on 3/24/19.					42
	congestive heart failur and osteoarthritis. The (Minimum Data Set) w	noses of but not limited to, re, dementia, depression,					
	5/26/19. The resident	was coded as moderately take daily life decisions.					
	note on 5/26/19 that down was sent to the hospital	record revealed a nurse's ocumented Resident #25 al for shortness of breath.					
	res, transferred to (nar	emergency room) for able. Call made to have ne of hospital) (name of				¥	
	town). Res. picked up (county) rescue squad	at 1520 (3:20 PM) via ."					
	what, if any, required d	o reveal any evidence of locumentation was ng facility. There was no					
	evidence of a transfer t	form which would contain formation was completed.					
	An interview was cond (administrative staff me nursing, on 6/5/19 at 2:	ucted with ASM ember) #2,, the director of 47 p.m., regarding what					

documentation the facility provide to the receiving hospital for residents that are transferred. ASM #2 stated, "Face sheet, med [medication] list,

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 06/18/2019 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED C 495226 B. WING 06/07/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW WAYLAND NURSING AND REHABILITATION CENTER KEYSVILLE, VA 23947 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION (X5)PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLÉTION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 622 Continued From page 24 F 622 DNR [do not resuscitate], order to send to the ER [emergency room], bed hold policy, immunization, lab (laboratory) or x-ray results. I then call 911, call the hospital with report." When asked if the staff send the comprehensive care plan goals, ASM #2 stated, "No, we do not." When asked if the doctor's write a note of why the resident went to the hospital, ASM #2 stated, "Sometimes." On 6/6/19 at 7:43 PM, ASM #1 (the Administrator), ASM #2 and ASM #4 (Facility Nurse Consultant) were notified of the concerns. ASM #1 inquired about a transfer form for the required transfer information and ASM #2 then stated that the facility does not use a transfer form. (1) BNP - Brain natriuretic peptide (BNP) test is a blood test that measures levels of a protein called BPN that is made by your heart and blood vessels. BNP levels are higher than normal when you have heart failure. Information obtained from https://medlineplus.gov/ency/article/007509.htm (2) Lasix - is a diuretic used to treat high blood pressure by reducing the excess water in the Information obtained from https://medlineplus.gov/druginfo/meds/a682858.h tml (3) Levaquin - is an antibiotic. Information obtained from https://medlineplus.gov/druginfo/meds/a697040.h

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DEPART	MENT OF HEALTH A	ND HUMAN SERVICES				M APPROVE
CENTER	RS FOR MEDICARE &	MEDICAID SERVICES				0. 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		SURVEY PLETED
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NAME OF P	ROVIDER OR SUPPLIER	493220	-	STREET ADDRESS, CITY, STATE, ZIP CODE	06	/07/201 <u>9</u>
				730 LUNENBURG HIGHW		
WAYLANI	NURSING AND REHAE	BILITATION CENTER	1	KEYSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 622	Continued From pag	e 25	F 622	2		
	documentation was proceed facility when Resident hospital on 2/15/19. Resident #13 was addiagnoses of atrial fibric depression, chronic of disease, anxiety disordisease, anxiety disordisease, anxiety disordisease, respiratordisease, respiratordisease, anxiety disordisease, anxiety disordisease, anxiety disordisease, anxiety disordisease, respiratordisease, respiratordisease, anxiety disordisease, anxiety disordise	al record revealed a nurse 9:00 a.m., that documented to the hospital for ing. The note documented "FNP (Family Nurse and order received to send om) for eval (evaluation) and age for RR. Bed Hold policy				
	"SNF/NF to Hospital 2/15/19 which docum demographic informated Alerts, Isolation Precafacility contact informated the status, reason for transport of the status, reason for transport in the status in	ented the resident's tion, code status, Risk autions, Skin/Wound Care, ation, Rehabilitation Therapy				

was sent to, and resident representative information. The area titled "Treatments: Respiratory....Diet....Medications...." documented that the resident was on nebulizer therapy for a

		ND HUMAN SERVICES MEDICAID SERVICES			FORM APPROVE
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	140	CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED
	ROVIDER OR SUPPLIER D NURSING AND REHAB	495226 ILITATION CENTER	73	TREET ADDRESS, CITY, STATE, ZIP CODE TO LUNENBURG HIGHW EYSVILLE, VA 23947	C 06/07/201 <u>9</u>
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	However, the reason was the dose. In add or treatments were do evidence that a copy Administration Record Administration Record provided. There was comprehensive care pathe receiving hospital. An interview was cond (administrative staff mursing, on 6/5/19 at 2 documentation the fact hospital for residents #2 stated, "Face shee DNR [do not resuscital [emergency room], be lab (laboratory) or x-racall the hospital with restaff send the comprehasm #2 stated, "No, verthe doctor's write a not to the hospital, ASM #4 On 6/6/19 at 7:43 PM, Administrator), ASM #7 Nurse Consultant) were ASM #1 inquired about required transfer informatics.	d was on Macrobid (3). was not documented nor ition, no other medications of the Medication d and Treatment d (MAR and TAR) were no evidence that the olan goals were provided to ducted with ASM member) #2,, the director of 2:47 p.m., regarding what cility provide to the receiving that are transferred. ASM t, med [medication] list, tte], order to send to the ER d hold policy, immunization, my results. I then call 911, eport." When asked if the mensive care plan goals, we do not." When asked if te of why the resident went 2 stated, "Sometimes." ASM #1 (the 2 and ASM #4 (Facility re notified of the concerns. It a transfer form for the mation and ASM #2 then does not use a transfer	F 622		

Information obtained from

https://medlineplus.gov/druginfo/meds/a601209.h

vomiting.

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PRINTED: 06/18/2019 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING_ COMPLETED C 495226 B. WING 06/07/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW WAYLAND NURSING AND REHABILITATION CENTER KEYSVILLE, VA 23947 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) DATE CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 622 Continued From page 27 F 622 (2) Phenergan - is used to prevent and control nausea and vomiting. Information obtained from https://medlineplus.gov/druginfo/meds/a682284.h tml 5. The facility staff failed to evidence that all required physician documentation was completed and evidence what, if any, required transfer documentations was provided to the receiving facility when Resident #15 was transferred to the hospital on 4/11/19. Resident #15 was admitted to the facility on 12/2/13 with the diagnoses of but not limited to dementia, with behavioral disturbances, anxiety disorder, Huntington's disease (1) and history of falling. The most recent MDS (Minimum Data Set), a Quarterly Medicare assessment, with an ARD (Assessment reference date) of 4/3/19. coded the resident per staff assessment, as having short-term memory problems, long-term memory problems, and severe impairment of daily decision-making. . A review of the clinical record revealed a nurse's noted dated 4/11/19 at 02:21 a.m., that documented in part, " ... observed resident on mat beside bed. no apparent injury found...Will send to ER [emergency room] for evaluation and treatment ..."

A review of the clinical record failed to reveal a physician's note documenting the reason for Resident #15's transfer to the hospital on 4/11/19.

(administrative staff member) #2,, the director of

An interview was conducted with ASM

		ID HUMAN SERVICES MEDICAID SERVICES			FOR	:D: 06/18/201
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATI	O. 0938-039 E SURVEY PLETED
	ROVIDER OR SUPPLIER D NURSING AND REHAB	495226	73	TREET ADDRESS, CITY, STATE, ZIP CODE 80 LUNENBURG HIGHW EYSVILLE, VA 23947	06	C 5/07/201 <u>9</u>
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 622	documentation the fact hospital for residents if #2 stated, "Face sheet DNR [do not resuscitate [emergency room], be lab (laboratory) or x-racall the hospital with restaff send the comprese ASM #2 stated, "No, with the doctor's write a not to the hospital, ASM #	2:47 p.m., regarding what cility provide to the receiving that are transferred. ASM t, med [medication] list, te], order to send to the ER d hold policy, immunization, ay results. I then call 911, eport." When asked if the hensive care plan goals, we do not." When asked if te of why the resident went 2 stated, "Sometimes."	F 622			
	Staff Member) #1, the aware of the findings. provided by the end of (1) Huntington's diseast that causes certain ne waste away. People at gene, but symptoms u middle age. Early symuncontrolled movemer balance problems. Lat ability to walk, talk, and stop recognizing family aware of their environrexpress emotions. This from the following web https://vsearch.nlm.nihmeta?v%3Aproject=memedlineplus-bundle&q	se: is an inherited disease rve cells in the brain to re born with the defective sually don't appear until ptoms of HD may include its, clumsiness, and er, HD can take away the diswallow. Some people members. Others are ment and are able to its information was obtained site: .gov/vivisimo/cgi-bin/query-edlineplus&v%3Asources= uery=huntington%27s+dise 1.349992197.1560176578-			# é	

6. The facility staff failed to evidence what, if any,

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DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 06/18/2019 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING C 495226 B. WING_ 06/07/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW WAYLAND NURSING AND REHABILITATION CENTER KEYSVILLE, VA 23947 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION **PREFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) Continued From page 29 F 622 F 622 required transfer documentations was provided to the receiving facility when Resident #43 was transferred to the hospital on 4/12/19, 5/5/19 and 5/6/19, and all required physician documentation was completed when Resident #43 was transferred to the hospital on 5/5/19. Resident #43 was admitted to the facility on 2/22/19 with the diagnoses of but not limited to dementia with behavioral disturbances, Alzheimer's disease, chronic kidney disease, and high blood pressure. The most recent MDS (Minimum Data Set), a Quarterly Medicare assessment, with an ARD (Assessment reference date) of 5/6/19, coded the resident per staff assessment as having short-term memory problems, long-term memory problems, and moderate impairment of daily decision-making. A review of the clinical record revealed a nurse's noted dated 4/12/19 at 10:15 a.m., documented in part, "Upon entering room resident noted sitting on floor in front of bed ...FNP (Family Nurse Practitioner) notified and order received to send to ER (Emergency Room) for eval and treatment. RR (Resident Representative) aware and bed hold policy given to RR in facility." A review of the clinical record revealed a physician's note dated 4/13/19 at 10:45 a.m.,

documented in part, " ... She was evaluated at (name of) hospital 4/12/19 ... She was found to

A review of the clinical record failed to evidence that the required transfer documents were provided to the receiving facility for Resident #43's transfer to the hospital on 4/12/19.

have a urinary tract infection ..."

		ID HUMAN SERVICES				ED: 06/18/2019 RM APPROVE
STATEMENT	OF DEFICIENCIES F CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		(X3) DA	NO. 0938-039 TE SURVEY MPLETED
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F 622	A review of the clinica noted dated 5/5/19 at in part, "Called to roomcalled FNP and order (emergency room) for treatment" A review of the clinical physician's note documents documents including to the clinical physician's note documents including to the clinical physician's note documents including the comments including the contents of the clinical note.	I record revealed a nurse's 7:10 a.m., that documented in due to resident vomiting er received to send to ER eval (evaluation) and I record failed to reveal a menting the reason for er to the hospital on 5/5/19. To evidence the required the comprehensive care the receiving facility when	F 622		a	18
	noted dated 5/6/19 at in part, "Resident with wheezecalled (nam ER for evaluation A review of the clinical physician's note dated documented in part, " (name of) hospital 5/6/found to have an EBS Beta-Lactamase) urinal A review of the clinical the required document	record revealed a 5/11/19 at 11:15 a.m., thatShe was evaluated at 19 - 5/9/19 for fever and L (Extended Spectrum ary tract infection" record failed to evidence is including the lan, were provided to the Resident #43 was	254	-		

An interview was conducted with ASM

(administrative staff member) #2,, the director of nursing, on 6/5/19 at 2:47 p.m., regarding what documentation the facility provide to the receiving

DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES): 06/18/201 /IAPPROVE	
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
WAYLAND NURSING AND REHABILITATION CENTER			- 1	730 LUNENBURG HIGHW KEYSVILLE, VA 23947			
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F 622	hospital for residents #2 stated, "Face sheed DNR [do not resuscitate [emergency room], be lab (laboratory) or x-racall the hospital with ristaff send the compre ASM #2 stated, "No, with the doctor's write a not to the hospital, ASM # On 6/7/19 at 11:48 AM Member) #1, the Adm of the findings. No fur provided by the end of the findings. No fur provided by the end of the receiving facility with the receiving facility with the diagnostic than the finding type 2 diabetes mellitus heart failure, chronic of disease (1), obstructive and retention of urine. (Minimum Data Set), a assessment, with an Adate) of 5/28/19, code 6 out of 15 on the BIM Mental Status) score, in the susceptible of the status is the second of the second of the second of the BIM Mental Status) score, in the second of the second of the BIM Mental Status) score, in the second of the second of the BIM Mental Status) score, in the second of the second of the BIM Mental Status) score, in the second of the BIM Mental Status) score, in the second of the BIM Mental Status) score, in the second of the second of the BIM Mental Status) score, in the second of the second of the BIM Mental Status) score, in the second of the second of the BIM Mental Status) score, in the second of the second of the BIM Mental Status) score, in the second of the second of the BIM Mental Status) score, in the second of	that are transferred. ASM et, med [medication] list, ate], order to send to the ER ed hold policy, immunization, ay results. I then call 911, eport." When asked if the hensive care plan goals, we do not." When asked if ote of why the resident went et et at the eta	F 622				

A review of the clinical record revealed a nurse's note dated 5/12/19 at 9:16 PM, documented in

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PRINTED: 06/18/2019 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING С 495226 B. WING 06/07/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW WAYLAND NURSING AND REHABILITATION CENTER KEYSVILLE, VA 23947 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION **PREFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) DATE CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 622 Continued From page 32 F 622 part, "No acute changes. (Name of) NP (Nurse Practitioner) aware of resident's complaints of chest pain and gave order to transport to ER (Emergency room) ..." A review of the clinical record revealed a physician's note dated 5/15/19 at 10 PM. documented in part, " ... He was evaluated at (name of) Hospital 5/13/19 - 5/15/19 for exacerbation of his congestive heart failure ..." A review of the clinical record failed to reveal what and if any of the required information was provided to the receiving facility when Resident #49 was transferred to the hospital on 5/12/19. An interview was conducted with ASM (administrative staff member) #2,, the director of nursing, on 6/5/19 at 2:47 p.m., regarding what documentation the facility provide to the receiving hospital for residents that are transferred. ASM #2 stated, "Face sheet, med [medication] list, DNR [do not resuscitate], order to send to the ER [emergency room], bed hold policy, immunization, lab (laboratory) or x-ray results. I then call 911, call the hospital with report." When asked if the staff send the comprehensive care plan goals. ASM #2 stated, "No, we do not." When asked if the doctor's write a note of why the resident went to the hospital, ASM #2 stated, "Sometimes."

On 6/7/19 at 11:48 AM, ASM (Administrative Staff Member) #1, the Administrator, was made aware of the findings. No further information was

provided by the end of the survey.

(1) Chronic obstructive pulmonary disease:
Disease that makes it difficult to breath that can

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		COMPLETED	
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	ROVIDER OR SUPPLIER D NURSING AND REHABILITATION CENTER	STRE 730 I KEY	00/07/20 13		
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F 622	Continued From page 33 lead to shortness of breath. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html. (2) Obstructive and reflux uropathy: Obstructive uropathy is a condition in which the flow of urine is blocked. This causes the urine to back up and injure one or both kidneys. This information was obtained from the website: https://medlineplus.gov/ency/article/000507.htm	F 622			
	8. The facility staff failed to what, if any, required transfer documentations was provided to the receiving facility when Resident #46 was transferred to the hospital on 5/28/19. Resident #46 was admitted to the facility on 9/18/17 with the diagnoses of but not limited to high blood pressure, heart attack, heart failure, chronic obstructive pulmonary disease (1), and asthma. The most recent MDS (Minimum Data Set), a five-day Medicare assessment, with an ARD (Assessment reference date) of 5/17/19, coded the resident as scoring a 13 out of 15 on the BIMS (Brief Interview for Mental Status) score, indicating the Resident had no cognitive impairment for daily decision making. The resident required extensive assistance for eating: total care for hygiene, bathing, dressing, toileting, and transfers; and was always incontinent of bladder and bowel. A review of the clinical record revealed a nurse's part detect 5/28/19 at 8/44 AM degree at the second for th				
	note dated 5/28/19 at 8:44 AM, documented in part, "order received from FNP (Family Nurse Practitioner) to send to ER (Emergency room) for				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED C	
		495226	B. WING		06/07/2019
NAME OF PROVIDER OR SUPPLIER WAYLAND NURSING AND REHABILITATION CENTER			5TR6 730 KEY	00/01/2013	
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F 622	eval and treatment A review of the clinical physician's note date documented in part, '(name of) Hospital 5/pain" A review of the clinical required transfer documented transfer documented transfer to the hospital to the receiving facility. An interview was considered in the factorial for residents #2 stated, "Face sheed DNR [do not resuscital [emergency room], but he laboratory) or x-rocall the hospital with staff send the compression of the factorial forms write and to the hospital, ASM ** On 6/7/19 at 11:48 A Member) #1, the Admof the findings. No fur provided by the end of the findings. No fur provided by the end of the findings.	al record revealed a d 5/20/19 at 8:45 PM, She was hospitalized at 28/19 - 6/3/19 for abdominal al record failed to reveal uments of Resident #46's al on 5/28/19 was provided by. ducted with ASM nember) #2,, the director of 2:47 p.m., regarding what cility provide to the receiving that are transferred. ASM bet, med [medication] list, ate], order to send to the ER bed hold policy, immunization, ay results. I then call 911, report." When asked if the enensive care plan goals, we do not." When asked if the of why the resident went #2 stated, "Sometimes." M, ASM (Administrative Staff ninistrator, was made aware rther information was of the survey.	F 622		
	Disease that makes i lead to shortness of t obtained from the we https://www.nlm.nih.g	re pulmonary disease: t difficult to breath that can breath. This information was bsite: bsi		2	

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING		COMPLETED		
		495226	B. WING		C 06/07/2019	
NAME OF PROVIDER OR SUPPLIER WAYLAND NURSING AND REHABILITATION CENTER			s ⁻	STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION	
F 622	facility the compreher Resident #19's transfer Resident #19's transfer Resident #19 was add 1/5/17 with a recent rediagnoses that included diabetes, high blood particles and anemia (combemoglobin content or limits) (1). The most recent MDS assessment, a quarter assessment reference resident as scoring a sinterview for mental stresident was severely cognitive decisions. The nurse's note dater documented in part, "I observed resident on beside his bed. He teld to stand from wheelch completedNeurologic he did not hit his head pain in right abdomen of 1-10 and complains (nurse practitioner) massend to ER (emergenceRR (resident representation of the physician's order "Send to ER for eval (constraint)."	sive care plan goals upon ar to the hospital on 3/7/19. Initted to the facility on padmission on 3/11/19 with ad but were not limited to: ressure, stroke, history of dition in which the facility assessment, with an date of 5/28/19, coded the 4" on the BIMS (brief atus) score, indicating the impaired to make daily Indicating resident call out, floor laying on his right side is nurse that he was trying air. Nursing assessment call assessment, tells nurse. Resident complains of rating 9 on the pain scale of shoulder pain. NP ade aware with orders to the total out, and the pain scale of shoulder pain. Near that it is not to the pain scale of shoulder pain. Near that it is not the pain scale of shoulder pain. Near that it is not the pain scale of shoulder pain. Near that it is not the pain scale of shoulder pain. Near that it is not the pain scale of shoulder pain. Near that it is not the pain scale of shoulder pain. Near that it is not the pain scale of shoulder pain. Near that it is not the pain scale of shoulder pain. Near that it is not the pain scale of shoulder pain. Near that it is not that it i	F 622			

(X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES

FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

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	495226	B. WING		06/07/2019
NAME OF F	PROVIDER OR SUPPLIER	5	STREET ADDRESS, CITY, STATE, ZIP CODE	-
14/41/4 4 4 1		, 7	730 LUNENBURG HIGHW	
WAYLAN	D NURSING AND REHABILITATION CENTER	J P	KEYSVILLE, VA 23947	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 622	Continued From page 36 staff member (ASM) #2, the director of nursing,	F 622		
	on 6/5/19 at 2:47 p.m. When asked what paperwork is sent with a resident on transfer to the hospital, ASM #2 stated, "The face sheet, med list, DNR form, order to send to the ER, bed hold policy, immunizations and any recent laboratory or x-ray results." When asked if the facility sends a copy of the comprehensive care plan goals, ASM #2 stated, "No, we do not."			
	Administrative staff member (ASM) #1, ASM #2 and ASM #4, the facility-nursing consultant, were made aware of the above findings on 6/6/19 at 7:35 p.m. No further information was provided prior to exit.			1-4
F 623 SS=E	(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 33. Notice Requirements Before Transfer/Discharge	F 623		
	§483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and			

(X2) MULTIPLE CONSTRUCTION

PRINTED: VOLIGIZO 19 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION A. BUILDING ___

(X3) DATE SURVEY

С

COMPLETED

495226

B. WING_

06/07/2019

NAME OF PROVIDER OR SUPPLIER

WAYLAND NURSING AND REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW

MANY AND AUDONO AND DELIABILITATION CENTED			KEYSVILLE, VA 23947		
MAI EARS ROTORIO FILIS INC. INC. INC. INC. INC. INC. INC. INC.		<u> </u>			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
Continued From page 37 (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in	F	623	The resident representative and the Ombudsman were sent proper written notification of a hospital transfer for resident #s 41, 22, 25, 13, 15, 43, 49, 46, and 19. A review of unplanned discharges for the previous 30 days was conducted and no other issues were found. Unplanned discharges will be reviewed by the Cardinal IDT. The Social worker will keep a log to indicate that proper notifications to the Resident representative and the Ombudsman was done. She will report her findings in the daily meeting as necessary. The Cardinal IDT will review the SS logs weekly to ensure and oversee compliance. Results of non-compliance will be immediately corrected and Reported to the facility QAPI committee monthly,	7/21/19	

	F CORRECTION	IDENTIFICATION NUMBER:		G	COMPLETED	
		40.500	D MINO			С
NAME OF F	ROVIDER OR SUPPLIER	495226	B. WING	STREET ADDRESS, CITY, ST		06/07/2019
WAYLAN	O NURSING AND REHAB	ILITATION CENTER		730 LUNENBURG HIGHW KEYSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	completing the form a hearing request; (v) The name, addrest telephone number of Long-Term Care Omtower of the protection and addevelopmental disabilities, the mailing telephone number of the protection and addevelopmental disabilities of the Developmental disabilities of the D	s (mailing and email) and the Office of the State budsman; residents with intellectual sabilities or related g and email address and the agency responsible for vocacy of individuals with lities established under Part tal Disabilities Assistance of 2000 (Pub. L. 106-402, 15001 et seq.); and y residents with a mental sabilities, the mailing and ephone number of the or the protection and als with a mental disorder Protection and Advocacy uals Act. The sto the notice. The notice changes prior to bor discharge, the facility ients of the notice as soon are updated information The advance of facility closure closure, the individual who is the facility must provide or to the impending closure gency, the Office of the combudsman, residents of sident representatives, as transfer and adequate	F 63	23		

	CORRECTION	IDENTIFICATION NUMBER:		SONSTRUCTION	COMPLETED
	2		E (==		С
	ROVIDER OR SUPPLIER D NURSING AND REHAB	495226 LITATION CENTER	st 73	REET ADDRESS, CITY, STATE, ZIP CODE LUNENBURG HIGHW SYSVILLE, VA 23947	06/07/201 <u>9</u>
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 623	483.70(I). This REQUIREMENT by: Based on staff intervireview, and clinical redetermined that the fathat the Ombudsman representative was protification of a hospit residents in the surve	is not met as evidenced ew, facility document cord review, it was cility staff failed to evidence	F 623		
	written notification of a provided to the reside Resident #41 was trait 4/16/19. Resident #41 was addressed and route respiratory failures pressure, anxiety disorder, atrial fibrillat chronic obstructive prosteoporosis. The modulate Data Set) was a signification of the resident of the	roses of but not limited to, re, diabetes, high blood order, breast cancer, bladder on, congestive heart failure, Imonary disease, and ost recent MDS (Minimum ficant change assessment ment Reference Date) of was coded as being in ability to make daily life			
	following nurses note: "Therapy alerted write (complaining of) stabb				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495226	B. WING			07/2040
NAME OF P	ROVIDER OR SUPPLIER	730220		STREET ADDRESS, CITY, STATE, ZIP CODE	06/	07/2019
WANT OF T	NOVIBER OR GOT TELER			30 LUNENBURG HIGHW		
WAYLAND	NURSING AND REHAB	ILITATION CENTER		KEYSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 623	@ (at) 3L/M (three lite assess resident. Res pain in left arm, non-re (shortness of breath). O2@3L/M. Resident questions. Speech sl pressure) 130/64, HR (respiratory rate) 22. Practitioner) made awasend to ER (emergenevaluation. Bed hold and sent with resident (responsible represent Further review failed twritten notification of the provided to the resident written notification of the provided to the resident to the Company. She stated the notification to the Company. She stated the notification to the Company. A review of the facility Discharge document transfers and company of the resident to remain transfer or discharge unless: a) The transfer or discharge unless: a) The transfer the resident's welforther esident's attendid documentation that si "b" have occurred	ers per minute). Writer in to ident continues to c/o sharp adiating. C/o SOB O2 sats 90% on slow to respond to writers urred at times. B/P (blood (heart rate) 134, RR (Name of Nurse vare and orders received to cy room) for further policy placed in paperwork t. Resident is her own RR attative) and aware." It or reveal any evidence that the hospital transfer was ent representative. M, in an interview with OSM per, the social worker) OSM and a written letter (to the hat she sends written budsman every week of the discharges.	F 623			

	F CORRECTION CAT IDENTIFICATION NUMBER:	A. BUILDING	CONSTRUCTION	COMPLETED
	495226	B. WING		C
	ROVIDER OR SUPPLIER D NURSING AND REHABILITATION CENTER	STF	REET ADDRESS, CITY, STATE, ZIP CODE D LUNENBURG HIGHW EYSVILLE, VA 23947	06/07/201 <u>9</u>
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 41 representative of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. *Record the reason(s) in the resident's clinical record." The policy did not include any criteria for the required components of the written notification of the Ombudsman. On 6/6/19 at 7:43 PM, ASM #1 (Administrative Staff Member - the Administrator), ASM #2 (the Director of Nursing) and ASM #4 (Facility Nurse Consultant) were notified of the concerns. No further information was provided by the end of the survey. (1) Tylenol - is used to treat mild to moderate pain and reduce fever. Information obtained from https://medlineplus.gov/druginfo/meds/a681004.html	F 623		
	2. The facility staff failed to evidence the required written notification of a hospital transfer was provided to the resident representative and the Ombudsman when the Resident #22 was transferred to the hospital on 3/11/19. In addition, failed to ensure that the resident representative was provided written notification when the resident was transferred to the hospital on 4/29/19. Resident #22 was admitted to the facility on 11/23/12 with the diagnoses of but not limited to dementia, atrial fibrillation, diabetes, chronic kidney disease, Alzheimer's disease, and psychotic disorder. The most recent MDS (Minimum Data Set) was an annual assessment with an ARD (Assessment Reference Date) of			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
2.		40.00			С
NAME OF B	ROVIDER OR SUPPLIER	495226	B. WING		06/07/2019
	O NURSING AND REHAI	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 730 LUNENBURG HIGHW KEYSVILLE, VA 23947	DDE
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE COMPLÉTION HE APPROPRIATE DATE
F 623	daily life decisions. A review of the clinic note dated 3/11/19 a Resident #22 was se from the wheelchair documented in part, notified and gave ord (emergency room) for RR (resident represence squad)." A nutricular sent with resident." Further review of the reveal evidence that and Ombudsman we documentation of the further review of the nurse's note dated, 4 documented the residence evaluation. The refollowing: "Writer cal a0915 (sic) (at 9:15 at to send to ER (emergency AM) (county) rescue message for RR (resideility. 0940 (9:40 A0945 (9:45 AM) Residend 2 attendants. At and no answer. 1240 representative) made	was coded as being mpaired in ability to make all record revealed a nurse is the 9:15 a.m., that documented into the hospital after a fall for evaluation. The note in in inverse practitioner in was ter to send to ER in the reval (evaluation) and treat. Intative) made aware. In the top of the following in the fo	F 6	23	
		the resident representative			

	F CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED
	495226	B. WING		C 06/07/2019
NAME OF PROVIDER OR SUPPLIER WAYLAND NURSING AND REHABILITATION CENTER		STRE	EET ADDRESS, CITY, STATE, ZIP CODE LUNENBURG HIGHW 'SVILLE, VA 23947	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	
F 623	Continued From page 43 was provided with written documentation of the hospital transfer.	F 623		
	On 6/06/19 at 7:22 PM, in an interview with OSM #4 (Other Staff Member, the social worker) OSM #4 stated, "I do not send a written letter (to the family)." She stated that she sends written notification to the Ombudsman every week of the recent transfers and discharges.	a	*	2
	On 6/07/19 at 7:50 AM, in a follow up interview with OSM #4, she stated that for Resident #22 the Ombudsman was not notified of the 3/11/19 transfer because the resident was a transfer to the emergency room and back, and was not admitted to the hospital. She provided evidence that she sent the Ombudsman notification on this morning, 6/7/19, approximately 3 months after the hospital transfer.		72	
	On 6/6/19 at 7:43 PM, ASM #1 (Administrative Staff Member - the Administrator), ASM #2 (the Director of Nursing) and ASM #4 (Facility Nurse Consultant) were notified of the concerns. No further information was provided by the end of the survey.			
	3. The facility staff failed to evidence the required written notification of a hospital transfer was provided to the resident representative and Ombudsman when Resident #25 was transferred to the hospital on 3/24/19.			
	Resident #25 was admitted to the facility on 7/30/18, with the diagnoses of but not limited to, congestive heart failure, dementia, depression, and osteoarthritis. The most recent MDS			

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ECONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	,				(c
		495226	B. WING	1044	06/	07/2019
NAME OF P	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, STATE, ZIP CODE		
MAVI AND	NURSING AND REHAB	II ITATION CENTED	1 7	30 LUNENBURG HIGHW		
VVATLANL	NURSING AND REHAB	ILITATION CENTER	ŀ	KEYSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 623	Continued From page	44	F 623		20	
		vas an annual assessment				
		ment Reference Date) of				
		t was coded as moderately nake daily life decisions.				
	impaired in ability to in	nake daily life decisions.				
	A review of the clinica	l record revealed a nurse's				
		locumented Resident #25	1			
		tal for shortness of breath.				
	The note documented	in part the following: (emergency room) for				_
		able. Call made to have				
	_	me of hospital) (name of				
		o at 1520 (3:20 PM) via				
	(county) rescue square					
	Further review failed t	o reveal any evidence of				
		esentative and Ombudsman				
	were provided with with hospital transfer.	itten documentation of the				
	On 6/06/19 at 7:22 PM	M, in an interview with OSM				
		er, the social worker) OSM				
		end a written letter (to the				
	family)." She stated t					
		budsman every week of the				Li I
	recent transfers and o	lischarges.			Н	
	On 6/07/19 at 7:50 AM	M, in a follow up interview				
		ted that for Resident #25				
	the Ombudsman was	not notified of the 3/24/19				
	transfer because the	resident was a transfer to				
		and back, and was not				
		al. She provided evidence				
		oudsman notification on this				
		oximately two and a half				
	months after the hosp	oitai transfer.				
	On 6/6/19 at 7:43 PM	, ASM #1 (Administrative				
	Staff Member - the Ad	Iministrator). ASM #2 (the				

	F CORRECTION	IDENTIFICATION NUMBER:	1	NG		COMPLETED
NAME OF P	ROVIDER OR SUPPLIER	495226	B. WING_	STREET ADDRESS, CITY, S	 TATE, ZIP CODE	C 06/07/201 <u>9</u>
	NURSING AND REHAB	ILITATION CENTER		730 LUNENBURG HIGHW KEYSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	((EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Director of Nursing) a Consultant) were not further information was survey.	e 45 and ASM #4 (Facility Nurse fied of the concerns. No as provided by the end of the uretic peptide (BNP) test is a	Fe	523		
	blood test that measu BPN that is made by vessels. BNP levels a you have heart failure Information obtained	res levels of a protein called your heart and blood are higher than normal when				
	pressure by reducing body. Information obtained	c used to treat high blood the excess water in the from bv/druginfo/meds/a682858.h				
	(3) Levaquin - is an a Information obtained https://medlineplus.go tml					
	written notification of provided to the reside	iled to evidence the required a hospital transfer was ent representative when nsferred to the hospital on				
	diagnoses of atrial fib depression, chronic o disease, anxiety dison hemiplegia, respirator bladder. The most re	mitted on 2/6/15 with the rillation, hypothyroidism, bstructive pulmonary rder, intestinal obstruction, ry failure, and neurogenic cent MDS (Minimum Data change assessment with an				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION 3	(X3) DATE SURVEY COMPLETED	
	495226	B. WING		C	
NAME OF P	ROVIDER OR SUPPLIER	D. 111110	STREET ADDRESS, CITY, STATE, ZIP CODE	06/07/201 <u>9</u>	
WAYLANI	NURSING AND REHABILITATION CENTER		730 LUNENBURG HIGHW KEYSVILLE, VA 23947		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLÉTION	
F 623	Continued From page 46 ARD (Assessment Reference Date) of 3/22/19. The resident was coded as moderately impaired in ability to make daily life decisions. A review of the clinical record revealed a nurse note dated 2/15/19 at 9:00 a.m., that documented the resident was sent to the hospital for evaluation after vomiting. The note documented in part the following: "FNP (Family Nurse Practitioner) notified and order received to send	F 62	23		
	to ER (emergency room) for eval (evaluation) and treatment. Left message for RR. Bed Hold policy sent with paperwork to ER." Further review of the clinical record failed to reveal evidence that the resident representative was provided with written documentation of the hospital transfer. On 6/06/19 at 7:22 PM, in an interview with OSM #44 (Other Staff Member, the social worker) OSM		1925		
	#4 stated, "I do not send a written letter (to the family)." She stated that she sends written notification to the Ombudsman every week of the recent transfers and discharges. On 6/6/19 at 7:43 PM, ASM #1 (Administrative Staff Member - the Administrator), ASM #2 (the Director of Nursing) and ASM #4 (Facility Nurse Consultant) were notified of the concerns. No further information was provided by the end of the survey. (1) Zofran - is used to prevent nausea and vomiting. Information obtained from https://medlineplus.gov/druginfo/meds/a601209.html				

	F CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED
	495226	B, WING		C
NAME OF PROVIDER OR SUPPLIER WAYLAND NURSING AND REHABILITATION CENTER		STRE	EET ADDRESS, CITY, STATE, ZIP CODE LUNENBURG HIGHW SVILLE, VA 23947	06/07/201 <u>9</u>
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLÉTION
F 623	Continued From page 47 (2) Phenergan - is used to prevent and control nausea and vomiting. Information obtained from https://medlineplus.gov/druginfo/meds/a682284.h tml 5. The facility staff failed to provide Resident #15's representative with the required written notification of why the resident was sent to the hospital on 4/11/19. Resident #15 was admitted to the facility on 12/2/13 with the diagnoses of but not limited to dementia, with behavioral disturbances, anxiety disorder, Huntington's disease (1) and history of falling. The most recent MDS (Minimum Data Set), a Quarterly Medicare assessment, with an ARD (Assessment reference date) of 4/3/19, coded the resident per staff assessment as having short-term memory problems, long-term memory problems, and severe impairment of daily decision-making. The resident required total care for hygiene, bathing, dressing, toileting, transfers, and eating; and was always incontinent of bladder and bowel. A review of the clinical record revealed a nurse's noted dated 4/11/19 at 02:21 AM, that documented in part, "observed resident on mat beside bed. no apparent injury foundWill send to ER for evaluation and treatment" Further review of the clinical record failed to reveal evidence of the required written notification being provided to Resident #15's Resident Representative for Resident #15's transfer to the hospital on 4/11/19.	F 623		

	F CORRECTION CAT IDENTIFICATION NUMBER:		CONSTRUCTION	COMPLETED
	•	1		С
	495226	B. WING	life in the second	06/07/2019
NAME OF P	ROVIDER OR SUPPLIER		TREET ADDRESS, CITY, STATE, ZIP CODE	
WAYLAND	NURSING AND REHABILITATION CENTER		30 LUNENBURG HIGHW	
		K	EYSVILLE, VA 23947	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION	(X5) COMPLETION
PREFIX TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	
			DEFICIENCY)	
F 623	Continued From page 48	F 623		
	practical nurse) #5 on 6/5/19 at 2:37 p.m. When			
	asked do you give the resident or resident			
	representative anything in writing as to why the			
	resident was sent to the hospital, LPN #5 stated,			
	"Usually we call them and tell them why they are			
	going."			
	An interview was conducted with ASM			
	(administrative staff member) #2, the director of			
	nursing, on 6/5/19 at 2:47 p.m. When asked if			
	the facility provides the resident and/or resident			
	representative anything in writing to explain why			
	they have gone to the hospital, ASM #2 stated,			
	"Not in writing, we explain to them when we call			
	them to let them know they are going." When			1
	asked who notifies the ombudsman, ASM #2			
	stated, "The social worker. If she is here the day			
	they go out she sends it, but if it happens over the weekend, she sends it Monday morning."			
	weekend, and sends it worlday morning.			
	On 6/7/19 at 11:48 AM, ASM (Administrative Staff			
	Member) #1, the Administrator, was made aware			
	of the findings. No further information was			
	provided by the end of the survey.			
	(1) Huntington's disease: is an inherited disease	.=		
	that causes certain nerve cells in the brain to			
	waste away. People are born with the defective			
	gene, but symptoms usually don't appear until			
	middle age. Early symptoms of HD may include			
	uncontrolled movements, clumsiness, and			
	balance problems. Later, HD can take away the			
	ability to walk, talk, and swallow. Some people			
	stop recognizing family members. Others are			
	aware of their environment and are able to			
	express emotions. This information was obtained			
	from the following website:			
	https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-		420	
	meta?v%3Aproject=medlineplus&v%3Asources=	1		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY PLETED	
		'	I A. BOILDIN		i.a	С
		495226	B. WING			/07/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP		
WAYLAND	NURSING AND REHAB	ILITATION CENTER	1	730 LUNENBURG HIGHW	ı	
71711 - 2711 1	THE TELL PLANTS			KEYSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
F 623			F 62	23		
		query=huntington%27s+dise 31.349992197.1560176578- 561				
	#43's representative v	led to provide Resident with the required written resident was sent to the /5/19, and 5/6/19.				
	2/22/19 with the diagratementia with behavioral Alzheimer's disease, high blood pressure. (Minimum Data Set), assessment, with an adate) of 5/6/19, coded assessment as having problems, long-term residential with the diagram of the	chronic kidney disease, and The most recent MDS a Quarterly Medicare ARD (Assessment reference I the resident per staff				
	noted dated 4/12/19 a part, " CNA (Certified to nurse that resident room resident noted sFNP (Family Nurse order received to senfor eval and treatmen Representative) awar to RR (resident represented dated 5/5/19 at part, "Called to room to the communication of the clinical part, "Called to room to the communication of the clinical part, "Called to room to the clinical part, "Called to room to the clinical part,"	e and bed hold policy given sentative) in facility." Il record revealed a nurse's 7:10 AM, documented in due to resident vomiting er received to send to ER				

	CORRECTION CONTROL IDENTIFICATION NUMBER:	1 1	CONSTRUCTION	COMPLETED
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	495226 ROVIDER OR SUPPLIER NURSING AND REHABILITATION CENTER	J 73	TREET ADDRESS, CITY, STATE, ZIP CODE O LUNENBURG HIGHW EYSVILLE, VA 23947	06/07/201 <u>9</u>
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 623	Continued From page 50 A review of the clinical record revealed a nurse's noted dated 5/6/19 at 4:58 PM, documented in part, "Resident with inspiratory expiratory wheezecalled (name of) NP new order send to ER for evaluation." Further review of the clinical record failed to reveal evidence of the required written notification being provided to Resident #43's Resident Representative regarding transfers on 4/12/19, 5/5/19, and 5/6/19. An interview was conducted with ASM (administrative staff member) #2, the director of nursing, on 6/5/19 at 2:47 p.m. When asked if the facility provides the resident and/or resident representative anything in writing to explain why they have gone to the hospital, ASM #2 stated, "Not in writing, we explain to them when we call them to let them know they are going." When asked who notifies the ombudsman, ASM #2 stated, "The social worker. If she is here the day they go out she sends it, but if it happens over the weekend, she sends it Monday morning." On 6/7/19 at 11:48 AM, ASM (Administrative Staff Member) #1, the Administrator, was made aware of the findings. No further information was provided by the end of the survey. 7. The facility staff failed to provide Resident #49's representative with the required written notification of why the resident was sent to the hospital on 5/12/19.	F 623		
	Resident #49 was admitted to the facility on 4/23/19 with the diagnoses of but not limited to type 2 diabetes mellitus, high blood pressure,			

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			COMPLE			
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NAME OF PROVIDER OR SUPPLIER WAYLAND NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947		06/07/201 <u>9</u>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	((EACH CORRECTIVE CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETION DATE	
F 623	Continued From page 51 heart failure, chronic obstructive pulmonary disease (1), obstructive and reflux uropathy (2), and retention of urine. The most recent MDS (Minimum Data Set), a 14-day Medicare assessment, with an ARD (Assessment reference date) of 5/28/19, coded the resident as scoring 6 out of 15 on the BIMS (Brief Interview for Mental Status) score, indicating the Resident has severe cognitive impairment for daily decision making. A review of the clinical record revealed a nurse' note dated 5/12/19 at 9:16 PM, documented in part, "No acute changes. (Name of) NP (Nurse Practitioner) aware of resident's complaints of chest pain and gave order to transport to ER (Emergency room)" Further review of the clinical record failed to reveal evidence of the required written notification being provided to Resident #49's Resident Representative regarding transfers on 5/12/19.	ce a ad	23			
	An interview was conducted with ASM (administrative staff member) #2, the director of nursing, on 6/5/19 at 2:47 p.m. When asked if the facility provides the resident and/or resident representative anything in writing to explain why they have gone to the hospital, ASM #2 stated, "Not in writing, we explain to them when we call them to let them know they are going." When asked who notifies the ombudsman, ASM #2 stated, "The social worker. If she is here the day they go out she sends it, but if it happens over the weekend, she sends it Monday morning." On 6/7/19 at 11:48 AM, ASM (Administrative Statember) #1, the Administrator, was made awar of the findings. No further information was	y y he				

PRINTED: 06/18/2019 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING C B. WING 495226 06/07/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW WAYLAND NURSING AND REHABILITATION CENTER KEYSVILLE, VA 23947 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION **PREFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 623 Continued From page 52 F 623 provided by the end of the survey. (1) Chronic obstructive pulmonary disease: Disease that makes it difficult to breath that can lead to shortness of breath. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html. (2) Obstructive and reflux uropathy: Obstructive uropathy is a condition in which the flow of urine is blocked. This causes the urine to back up and injure one or both kidneys. This information was obtained from the website: https://medlineplus.gov/ency/article/000507.htm 8. The facility staff failed to provide Resident #46's representative with the required written notification of why the resident was sent to the hospital on 5/28/19. Resident #46 was admitted to the facility on9/18/17 with the diagnoses of but not limited to high blood pressure, heart attack, heart failure, chronic obstructive pulmonary disease (1), and asthma. The most recent MDS (Minimum Data Set), a five-day Medicare assessment, with an ARD (Assessment reference date) of 5/17/19, coded the resident as scoring a 13 out of 15 on the BIMS (Brief Interview for Mental Status) score, indicating the Resident had no cognitive impairment for daily decision making.

eval and treatment ..."

A review of the clinical record revealed a nurse's note dated 5/28/19 at 8:44 AM, documented in part, " ...order received from FNP (Family Nurse Practitioner) to send to ER (Emergency room) for

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING		(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER WAYLAND NURSING AND REHABILITATION CENTER		STRE 730 L KEY	06/07/201 <u>9</u>		
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	Continued From page 53 A review of the clinical record revealed a physician's note dated 5/20/19 at 8:45 PM, documented in part, "She was hospitalized at (name of) Hospital 5/28/19 - 6/3/19 for abdominal pain" Further review of the clinical record failed to reveal evidence of the required written notification being provided to the Resident #46's Resident Representative regarding the transfer to the hospital on 5/28/19. An interview was conducted with ASM (administrative staff member) #2, the director of nursing, on 6/5/19 at 2:47 p.m. When asked if the facility provides the resident and/or resident representative anything in writing to explain why they have gone to the hospital, ASM #2 stated, "Not in writing, we explain to them when we call them to let them know they are going." When asked who notifies the ombudsman, ASM #2 stated, "The social worker. If she is here the day they go out she sends it, but if it happens over the weekend, she sends it Monday morning." On 6/7/19 at 11:48 AM, ASM (Administrative Staff Member) #1, the Administrator, was made aware of the findings. No further information was provided by the end of the survey. (1) Chronic obstructive pulmonary disease: Disease that makes it difficult to breath that can lead to shortness of breath. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html. 9. The facility staff failed to provide the resident and/or the resident representative with a written notification as to the reason the resident was transferred to the hospital on 3/7/19 for Resident	F 623			

	OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA DEFICIENCIES IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING		(X3) DATE SURVEY COMPLETED
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F 623	Continued From page 54 #19. Resident #19 was admitted to the facility on 1/5/17 with a recent readmission on 3/11/19 with diagnoses that included but were not limited to: diabetes, high blood pressure, stroke, history of falls and anemia (condition in which the hemoglobin content of the blood is below normal limits) (1). The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 5/28/19, coded the resident as scoring a "4" on the BIMS (brief interview for mental status) score, indicating the resident was severely impaired to make daily cognitive decisions. The nurse's note dated, 3/7/19 at 10:45 a.m. documented in part, "Hearing resident call out, observed resident on floor laying on his right side beside his bed. He tells nurse that he was trying to stand from wheelchair. Nursing assessment completedNeurological assessment, tells nurse he did not hit his head. Resident complains of pain in right abdomen rating 9 on the pain scale of 1-10 and complains of shoulder pain. NP (nurse practitioner) made aware with orders to send to ER (emergency room) for evaluationRR (resident representative) made aware, report called to ER at (name of hospital)." The physician's order dated 3/7/19 documented, "Send to ER for eval (evaluation), S/P (status post fall)." An interview was conducted with LPN (licensed practical nurse) #5 on 6/5/19 at 2:37 p.m. When asked if she or anyone in the facility provides	F 623		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
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	1		,	KEYSVILLE, VA 23947		
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F 623	Continued From page	55	F 623			
	representative of the r	the resident and/or resident reason why the resident is LPN #5 stated, "No, we ell them why they are going e clinical record."				
	staff member (ASM) # on 6/5/19 at 2:47 p.m. resident and/or the RF why they went to the h	ducted with administrative t2, the director of nursing, When asked if you give the anything in writing as to nospital, ASM #2 stated, plain to them on the phone				
	and ASM #4, the facili	ember (ASM) #1, ASM #2 ty-nursing consultant, were ove findings on 6/6/19 at	o [®]			
	No further information	was provided prior to exit.				
F 625 SS=E	Non-Medical Reader, Chapman, page 33.	of Medical Terms for the 5th edition, Rothenberg and licy Before/Upon Trnsfr	F 625			
	§483.15(d) Notice of b	ed-hold policy and return-		<u>.</u>		
	nursing facility transfe the resident goes on the nursing facility must puthe resident or resident specifies- (i) The duration of the	rovide written information to at representative that state bed-hold policy, if resident is permitted to		27		

PRINTED: 00/10/2019 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING _ C 06/07/2019 495226 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 730 LUNENBURG HIGHW WAYLAND NURSING AND REHABILITATION CENTER KEYSVILLE, VA 23947 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID COMPLETION (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY F 625 Continued From page 56 F 625 Notification of our bed Hold facility: policy was provided to (ii) The reserve bed payment policy in the state Resident #' 41, 22, 13, 15, 43, plan, under § 447.40 of this chapter, if any; 49, and 46 and also to their (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with Resident Representative. paragraph (e)(1) of this section, permitting a resident to return; and A review of unplanned (iv) The information specified in paragraph (e)(1) discharges for the previous 30 of this section. days was conducted and no §483.15(d)(2) Bed-hold notice upon transfer. At issues were found. the time of transfer of a resident for Licensed Nursing Staff will be hospitalization or therapeutic leave, a nursing in-serviced on the Bed hold facility must provide to the resident and the resident representative written notice which Policy and the requirement specifies the duration of the bed-hold policy that it be included in the described in paragraph (d)(1) of this section. transfer packet. The Cardinal This REQUIREMENT is not met as evidenced by: IDT members will review Based on staff interview, facility document unplanned discharges in its review, and clinical record review, it was morning meeting to ensure determined that the facility staff failed to evidence that a written bed hold notice was provided to the compliance. The Social resident and/or resident representative in a timely worker will maintain a log that manner for seven of 33 residents in the survey verifies and ensures that the sample; Residents #41, #22, #13, #15, #43, #49, Resident and Resident and #46. Representative received proper notification of the Bed The findings include: Hold Policy.

1. The facility staff failed to evidence that a bed

hold notice was provided to the resident

representative when Resident #41 was transferred to the hospital on 4/29/19.

Resident #41 was admitted to the facility on

7/10/18 with the diagnoses of but not limited to,

acute respiratory failure, diabetes, high blood

The unplanned Discharges log

notifications and results of the

will be reviewed weekly for

compliance with proper

reviews submitted to the

facility's QAPI Committee at

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PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EA	PROVIDER'S PLAN OF CORRECTION (X5) CH CORRECTIVE ACTION SHOULD BE COMPLETION SS-REFERENCED TO THE APPROPRIATE DEFICIENCY) CX5) COMPLETION DATE
F 625 Continued From page 57 pressure, anxiety disorder, breast cancer, bladder disorder, atrial fibrillation, congestive heart failure, chronic obstructive pulmonary disease, and osteoporosis. The most recent MDS (Minimum Data Set) was a significant change assessment with an ARD (Assessment Reference Date) of 5/3/19. The resident was coded as being moderately impaired in ability to make daily life decisions. A review of the clinical record revealed the following nurses note: 4/16/19 at 3:39 PM: "Therapy alerted writer that resident was c/o (complaining of) stabbing pain in left arm and o2 [oxygen] sats [saturations] were in the 80's on O2 (eat) 3L/M (three liters per minute). Writer in to assess resident. Resident continues to c/o sharp pain in left arm, non-radiating. C/o SOB (shortness of breath). O2 sats 90% on O2/@3L/M. Resident slow to respond to writers questions. Speech slurred at times. B/P (blood pressure) 130/64, HR (heart rate) 134, RR (respiratory rate) 22. (Name of Nurse Practitioner) made aware and orders received to send to ER (emergency room) for further evaluation. Bed hold policy placed in paperwork and sent with resident. Resident is her own RR (responsible representative) and aware." Further review of the clinical record failed to reveal evidence that the resident representative was provided with the written bed hold notification. An interview was conducted with LPN (licensed practical nurse) #5 on 6/5/19 at 2:37 p.m., regarding the facility process for bed hold when a resident is sent to the hospital. When asked where do you document what was sent to the	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	COME	PLETED
		495226	B. WING				C 07/2019
NAME OF PROVIDER OR SUPPLIER WAYLAND NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947			011201 <u>3</u>
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F 625	the bed hold." A review of the facil Discharge" revealed criteria for the provision policy. On 6/6/19 at 7:43 P Staff Member - the Director of Nursing) Consultant) were not further information was urvey. 2. The facility staff hold notice was prove representative when transferred to the hold notice was prove representative when transferred to the hold congestive heart fai and osteoarthritis. (Minimum Data Set with an ARD (Asses 5/26/19. The reside impaired in ability to A review of the clinic	ty policy, "Transfer and I the policy did not include any sion of a written bed hold M, ASM #1 (Administrative Administrator), ASM #2 (the and ASM #4 (Facility Nurse tified of the concerns. No was provided by the end of the and according to the resident Resident #25 was applied to the facility on agnoses of but not limited to, ure, dementia, depression, The most recent MDS awas an annual assessment sment Reference Date) of ant was coded as moderately make daily life decisions.	F	625		754	
	was sent to the hos The note document "Order to send to El evaluation. RP agra res, transferred to (i	documented Resident #25 pital for shortness of breath. ed in part the following: R (emergency room) for eeable. Call made to have name of hospital) (name of up at 1520 (3:20 PM) via ad."					

	CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 625	Further review of the clinical record failed to reveal evidence that the resident representative was provided with the written bed hold notification. An interview was conducted with LPN (licensed practical nurse) #5 on 6/5/19 at 2:37 p.m., regarding the facility process for bed hold when a resident is sent to the hospital. When asked where do you document what was sent to the hospital, LPN #5 stated, "We write a note about the bed hold." On 6/6/19 at 7:43 PM, ASM #1 (Administrative Staff Member - the Administrator), ASM #2 (the Director of Nursing) and ASM #4 (Facility Nurse Consultant) were notified of the concerns. No further information was provided by the end of the survey. (1) BNP - Brain natriuretic peptide (BNP) test is a blood test that measures levels of a protein called BPN that is made by your heart and blood vessels. BNP levels are higher than normal when you have heart failure. Information obtained from https://medlineplus.gov/ency/article/007509.htm (2) Lasix - is a diuretic used to treat high blood pressure by reducing the excess water in the body. Information obtained from https://medlineplus.gov/druginfo/meds/a682858.h tml	F 625		
	(3) Levaquin - is an antibiotic. Information obtained from https://medlineplus.gov/druginfo/meds/a697040.h			

	OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA F CORRECTION IDENTIFICATION NUMBER:	(X2) MULTIPLE CC		(X3) DAITE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	.D BE COMPLÉTION
F 625	Continued From page 60 tml	F 625		
	3. The facility staff failed to evidence that a bed hold notice was provided to the resident representative when Resident #13 was transferred to the hospital on 2/15/19.			
	Resident #13 was admitted on 2/6/15 with the diagnoses of atrial fibrillation, hypothyroidism, depression, chronic obstructive pulmonary disease, anxiety disorder, intestinal obstruction, hemiplegia, respiratory failure, and neurogenic bladder. The most recent MDS (Minimum Data Set) was a significant change assessment with an ARD (Assessment Reference Date) of 3/22/19. The resident was coded as moderately impaired in ability to make daily life decisions.			
	A review of the clinical record revealed a nurse note dated 2/15/19 at 9:00 a.m., that documented the resident was sent to the hospital for evaluation after vomiting. The note documented in part the following: "FNP (Family Nurse Practitioner) notified and order received to send to ER (emergency room) for eval (evaluation) and treatment. Left message for RR. Bed Hold policy sent with paperwork to ER."		8	
	Further review of the clinical record failed to reveal evidence that the resident representative was provided with the written bed hold notification within the required 24-hour time frame of the hospital transfer. The note documenting the bed hold notice being provided was 7 days after the resident was transferred.			
	An interview was conducted with LPN (licensed practical nurse) #5 on 6/5/19 at 2:37 p.m			

	F CORRECTION	IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	COMPLETED
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NAME OF P	ROVIDER OR SUPPLIER	495226		STREET ADDRESS, CITY, STATE, ZIP CODE	06/07/201 <u>9</u>
WAYLANI	D NURSING AND REHAB	ILITATION CENTER		730 LUNENBURG HIGHW KEYSVILLE, VA 23947	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION
F 625	regarding the facility president is sent to the where do you docume hospital, LPN #5 state the bed hold." On 6/6/19 at 7:43 PM Staff Member - the Ac Director of Nursing) a Consultant) were notifurther information was survey. (1) Zofran - is used to vomiting. Information obtained the https://medlineplus.gottml (2) Phenergan - is used to vomiting. Information obtained the https://medlineplus.gottml 4. The facility staff fail #15's representative whold policy within the interesident was trans 4/11/19. Resident #15 was adr 12/2/13 with the diagradementia, with behavid disorder, Huntington's falling. The most received services of the control o	process for bed hold when a hospital. When asked ent what was sent to the ed, "We write a note about "ASM #1 (Administrative Iministrator), ASM #2 (the Ind ASM #4 (Facility Nurse Ited of the concerns. No is provided by the end of the prevent nausea and "From Ited to prevent and control from Ited to prevent and control from Ited to provide Resident written notification of the bed required timeframe when Iterred to the hospital on	F 625		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE COI	NSTRUCTION	C (X3) DATE SURVEY
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F 625	Continued From pa	•	F 625		
	having short-term r	per staff assessment as nemory problems, long-term and severe impairment of ing.		71	
	noted dated 4/11/1 documented in par	ical record revealed a nurse's 9 at 02:21 AM, that t, "observed resident on mat parent injury foundWill send n and treatment"			
	reveal evidence of of the bed hold pol	ne clinical record failed to the required written notification icy within the required e resident was transferred to 1/19.		2) 20	
	practical nurse) #5 regarding the facili resident is sent to t where do you docu	onducted with LPN (licensed on 6/5/19 at 2:37 p.m., by process for bed hold when a sthe hospital. When asked liment what was sent to the stated, "We write a note about			
	Member) #1, the A	AM, ASM (Administrative Staff dministrator, was made aware further information was d of the survey.			
	that causes certain waste away. Peopl gene, but symptom middle age. Early suncontrolled move balance problems. ability to walk, talk,	sease: is an inherited disease in nerve cells in the brain to le are born with the defective in usually don't appear until symptoms of HD may include ments, clumsiness, and Later, HD can take away the land swallow. Some people amily members. Others are			

	F CORRECTION (X1) PROVIDER/SUPPLIER/CLIA	A. BUILDING		COMPLETED
NAME OF P	495226 ROVIDER OR SUPPLIER		EET ADDRESS, CITY, STATE, ZIP CODE	C 06/07/201 <u>9</u>
WAYLAND	NURSING AND REHABILITATION CENTER		SVILLE, VA 23947	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 625	Continued From page 63 aware of their environment and are able to express emotions. This information was obtained from the following website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query- meta?v%3Aproject=medlineplus&v%3Asources= medlineplus-bundle&query=huntington%27s+dise ase&_ga=2.114498181.349992197.1560176578- 904618792.1557758561	F 625		
	5. The facility staff failed to provide Resident #43's representative written notification of the bed hold policy within the required timeframe when the resident was transferred to the hospital on 5/5/19, and 5/6/19. Resident #43 was admitted to the facility on 2/22/19 with the diagnoses of but not limited to dementia with behavioral disturbances, Alzheimer's disease, chronic kidney disease, and high blood pressure. The most recent MDS (Minimum Data Set), a Quarterly Medicare assessment, with an ARD (Assessment reference date) of 5/6/19, coded the resident per staff assessment as having short-term memory problems, long-term memory problems, and moderate impairment of daily decision-making. A review of the clinical record revealed a nurse's noted dated 5/5/19 at 7:10 AM, documented in			
	noted dated 5/5/19 at 7:10 AM, documented in part, "Called to room due to resident vomitingcalled FNP (family nurse practitioner) and order received to send to ER (emergency room) for eval (evaluation) and treatment" A review of the clinical record revealed a nurse's noted dated 5/6/19 at 4:58 PM, documented in part, "Resident with inspiratory expiratory wheeze			

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING		COMPLETED		
	495226	B. WING		C 06/07/2019		
	ROVIDER OR SUPPLIER D NURSING AND REHABILITATION CENTER	730	EET ADDRESS, CITY, STATE, ZIP CODE LUNENBURG HIGHW YSVILLE, VA 23947			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION		
F 625	Continued From page 64called (name of) NP new order send to ER [emergency room] for evaluation." Further review of the clinical record failed to reveal evidence of the required written notification of the bed hold policy within the required timeframe for Resident #43's transfers on 5/5/19, and 5/6/19. An interview was conducted with LPN (licensed practical nurse) #5 on 6/5/19 at 2:37 p.m., regarding the facility process for bed hold when a resident is sent to the hospital. When asked where do you document what was sent to the hospital, LPN #5 stated, "We write a note about the bed hold." On 6/7/19 at 11:48 AM, ASM (Administrative Staff Member) #1, the Administrator, was made aware of the findings. No further information was provided by the end of the survey.	F 625				
	6. The facility staff failed to provide Resident #49's representative written notification of the bed hold policy within the required timeframe when the resident was transferred to the hospital on 5/12/19. Resident #49 was admitted to the facility on 4/23/19 with the diagnoses of but not limited to type 2 diabetes mellitus, high blood pressure, heart failure, chronic obstructive pulmonary disease (1), obstructive and reflux uropathy (2), and retention of urine. The most recent MDS (Minimum Data Set), a 14-day Medicare assessment, with an ARD (Assessment reference date) of 5/28/19, coded the resident as scoring a 6 out of 15 on the BIMS (Brief Interview for		**			

	F CORRECTION (X1) PROVIDER/SUPPLIER/CLIA	` '	CONSTRUCTION	COMPLETED	
	495226	B. WING		C	
	ROVIDER OR SUPPLIER D NURSING AND REHABILITATION CENTER	s ⁻	TREET ADDRESS, CITY, STATE, ZIP CODE 30 LUNENBURG HIGHW EYSVILLE, VA 23947	06/07/201 <u>9</u>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
F 625	Continued From page 65 Mental Status) score, indicating the Resident had severe cognitive impairment for daily decision making. A review of the clinical record revealed a nurse's note dated 5/12/19 at 9:16 PM, documented in part, "No acute changes. (Name of) NP (Nurse Practitioner) aware of resident's complaints of chest pain and gave order to transport to ER	F 625	¥		
	(Emergency room)" Further review of the clinical record failed to reveal evidence of the required written notification of the bed hold policy within the required timeframe for Resident #49's transfers on 5/12/19. An interview was conducted with LPN (licensed practical nurse) #5 on 6/5/19 at 2:37 p.m., regarding the facility process for bed hold when a resident is sent to the hospital. When asked		2		
	where do you document what was sent to the hospital, LPN #5 stated, "We write a note about the bed hold." On 6/7/19 at 11:48 AM, ASM (Administrative Staff Member) #1, the Administrator, was made aware of the findings. No further information was provided by the end of the survey.	4)			
	 (1) Chronic obstructive pulmonary disease: Disease that makes it difficult to breath that can lead to shortness of breath. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html. (2) Obstructive and reflux uropathy: Obstructive uropathy is a condition in which the flow of urine is blocked. This causes the urine to back up and 			<	

	F CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	ROVIDER OR SUPPLIER D NURSING AND REHABILITATION CENTER	9730	REET ADDRESS, CITY, STATE, ZIP CODE D LUNENBURG HIGHW EYSVILLE, VA 23947	06/07/201 <u>9</u>
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 625	Continued From page 66 injure one or both kidneys. This information was obtained from the website: https://medlineplus.gov/ency/article/000507.htm	F 625		
as Na	7. The facility staff failed to provide Resident #46's representative written notification of the bed hold policy when the resident was transferred to the hospital on 5/28/19.			
	Resident #46 was admitted to the facility on9/18/17 with the diagnoses of but not limited to high blood pressure, heart attack, heart failure, chronic obstructive pulmonary disease (1), and asthma. The most recent MDS (Minimum Data Set), a five-day Medicare assessment, with an ARD (Assessment reference date) of 5/17/19, coded the resident as scoring a 13 out of 15 on the BIMS (Brief Interview for Mental Status) score, indicating the Resident had no cognitive impairment for daily decision making.			
	A review of the clinical record revealed a nurse's note dated 5/28/19 at 8:44 AM, documented in part, "order received from FNP (Family Nurse Practitioner) to send to ER (Emergency room) for eval and treatment"	х.		
	Further review of the clinical record failed to reveal evidence of the required written notification of the bed hold policy within the required timeframe of Resident #46's transfer to the hospital on 5/28/19.			
	An interview was conducted with LPN (licensed practical nurse) #5 on 6/5/19 at 2:37 p.m., regarding the facility process for bed hold when a resident is sent to the hospital. When asked	E4		8 0

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				E CONSTRUCTION	COMPLETED	
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		495226				07/2019
	ROVIDER OR SUPPLIER NURSING AND REHAB	ILITATION CENTER	1 7	STREET ADDRESS, CITY, STATE, ZIP 730 LUNENBURG HIGHW KEYSVILLE, VA 23947	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 625	where do you docume hospital, LPN #5 state the bed hold." On 6/7/19 at 11:48 AM Member) #1, the Adm of the findings. No fu provided by the end of	ent what was sent to the ed, "We write a note about A, ASM (Administrative Staff inistrator, was made aware of the survey.	F 625			
F 641 SS=D	lead to shortness of b obtained from the wel https://www.nlm.nih.g Accuracy of Assessm CFR(s): 483.20(g) §483.20(g) Accuracy The assessment mus resident's status. This REQUIREMENT by: Based on staff interviand clinical record reviacility staff failed to e	difficult to breath that can reath. This information was esite: ov/medlineplus/copd.html. ents of Assessments. t accurately reflect the is not met as evidenced ew facility document review riew, it was determined the	F 641	× ×	ži.	
	for one of 33 residents. Resident #27. The findings include: The facility staff failed C of the quarterly ass (assessment reference)	to accurately code Section essment with an ARD e date) of 4/29/19, the ith an ARD of 1/28/19 and tent with an ARD of			*	

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CENTER	S FOR MEDICARE &	VIEDICAID SERVICES	r			(Y3) DATE	SURVEY
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
AND PLAN OF	CONNECTION	lo	A. BUILDI	NG			
		495226	B. WING		, , , , , , , , , , , , , , , , , , ,	06/0	07/2019
NAME OF PE	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
MANANCE A NUM	NURSING AND REHAB	II ITATION CENTER			30 LUNENBURG HIGHW		9
WAYLAND	NUKSING AND REHAB	ENATION CENTER		K	EYSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E ATE	(X5) COMPLETION DATE
	Resident #27 was add 1/31/04 with diagnose limited to: stroke, dep pressure and Parkins progressive neurolog by resting tremor, show rolling motions of the weakness, sometime (1). The most recent MDS assessment, a quarte ARD of 4/29/19, code Hearing, Speech and making himself under understanding others Patterns, the resident completed. The staff The resident was cool long-term memory dinaving modified indecognitive decisions, a situations only. The annual assessm coded the resident in Speech and Vision a understood and usual Section C - Cognitive interview was not col was completed. The having both short an	mitted to the facility on as that included but were not ression, high blood on's Disease (a slowly ical disorder characterized uffling gait, stooped posture, fingers, drooling and muscles with emotional instability) 6 (minimum data set) and the resident in Section B-Vision as sometimes as tood and usually. In Section C - Cognitive to interview was not interview was not interview was completed. It was coded as pendence in making daily some difficulty in new ent, with an ARD of 1/28/19, Section B - Hearing, as sometimes making himself ally understanding others. In a Patterns, the resident mpleted. The staff interview resident was coded as	TAG		CROSS-REFERENCED TO THE APPROPRIA	esed o er	1/21/9
12	independence in ma some difficulty in nev	king daily cognitive decisions,					

10/31/19, coded the resident in Section B -

	F CORRECTION (X1) PROVIDER/SUPPLIER/CLIA	A. BUILDING		COMPLETED
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NAME OF P	495226 ROVIDER OR SUPPLIER	B. WINGSTRE	EET ADDRESS, CITY, STATE, ZIP CODE	06/07/201 <u>9</u>
WAYLAND	NURSING AND REHABILITATION CENTER		LUNENBURG HIGHW 'SVILLE, VA 23947	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	SE COMPLÉTION
F 641	Continued From page 69 Hearing, Speech and Vision as sometimes making himself understood and usually understanding others. In Section C - Cognitive Patterns, the resident interview was not completed. The staff interview was completed. The resident was coded as having both short and long-term memory difficulties and was coded as having modified independence in making daily cognitive decisions, some difficulty in new situations only. The instructions on the top of the page for Section C - Cognitive Patterns, documented, "Should Brief Interview for Mental Status be Conducted? Attempt to conduct interview with all residents. Code: 0. No (resident is rarely/never understood) - skip to and complete C0700-C1000, Staff Assessment for Mental Status. Code 1. Yes, Continue to C0200, Repetition of Three Words." The resident was coded on all three MDS assessments above as a Zero; resident is rarely/never understood. At the bottom of the Section it is documented, "C0500 - BIMS (brief interview for mental status) Score - Enter 99 if the resident was unable to complete the interview." An interview was conducted on 6/5/19 at 1:54 p.m. with RN (registered nurse) #1, the MDS coordinator. When asked who completes Section C of the MDS assessments, RN #1 stated the social worker. When asked who completes Section B, RN #1 stated that she did Section B. RN #1 was asked to review the above MDS assessment in Section B and Section C. RN #1 stated, "It (the interview) should have been completed. He is not rarely/never understood.	F 641		
	An interview was conducted with OSM (other staff			

	F CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	495226	B. WING		C 06/07/2019	
	PROVIDER OR SUPPLIER D NURSING AND REHABILITATION CENTER	73	REET ADDRESS, CITY, STATE, ZIP CODE 0 LUNENBURG HIGHW EYSVILLE, VA 23947	06/07/201 <u>9</u>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLÉTION	
	Continued From page 70 member) #4, the social worker, on 6/5/19 at 2:01 p.m. When asked if she reads Section B prior to completing Section C, OSM #4 stated, "No, Ma'am." The above MDS assessments, Section C were reviewed with OSM #4. OSM #4 stated, "When I ask him the questions he only replies "bowlly ball." When asked which reference the facility uses to complete the MDS assessments, OSM #4 stated, "The RAI (resident assessment instrument) manual." The facility document, the RAI manual, documented in part, "Coding Instructions- Code 0, no: if the interview should not be attempted because the resident is rarely/never understood, cannot respond verbally or in writing; or an interpreter is needed but not available. Code1, yes: if the interview should be attempted because the resident is at least sometimes understood verbally or in writing, and if an interpreter is needed, one is availableIf the interview is stopped, do the following: 1. Code -, dash in C0400A, C0400B, and C0400C. 2. Code 99 in the summary score in C0500. 3. Code 1, yes, in C0600 Should the Staff Assessment for Mental Status be Conducted? 4. Complete the Staff Assessment for Mental Status." Administrative staff member (ASM) #1, the administrator, and ASM #4, the facility nurse consultant, were made aware of the above findings on 6/6/19 at 7:45 a.m. No further information was provided prior to exit. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 437.	F 641			

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NAME OF PROVIDER OR SUPPLIER WAYLAND NURSING AND REHABILITATION CENTER (X4) ID PREFIX TAG (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 656 F 656 SS=E Continued From page 71 Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at \$483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
WAYLAND NURSING AND REHABILITATION CENTER (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 656 F 656 F 656 Continued From page 71 Develop/Implement Comprehensive Care Plan S483.21(b)(1) FRESIZ (EACH OERICIENCY) F 656 F 656 SS=E F 656 F 656 SS=E F 656 R 656 F 656			495226			C 06/07/201 <u>9</u>
FRÉFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F 656 Continued From page 71 F 656 SS=E CFR(s): 483.21(b)(1) \$\frac{483.21(b)}{2}\$ (Develop/Implement Comprehensive Care Plan S\(\frac{483.21(b)}{2}\$) (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at \$\frac{483.10(c)}{2}\$ and \$\frac{8483.10(c)}{2}\$ and seasesment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as			ILITATION CENTER	1 7	730 LUNENBURG HIGHW	
F 656 SS=E Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) \$483.21(b) Comprehensive Care Plans \$483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (I) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR	ULD BE COMPLETIO
required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate compliance. Nursing staff members will receive monthly in-services on the resident care plans to ensure continued compliance and also to be aware of any care plan updates or changes. The Director of Nursing or her designee will conduct weekly checks to determine that care plans are being followed. The results of the checks will be discussed in the Cardinal IDT meetings and results submitted to the facility QAPI committee.	F 656 SS=E	Develop/Implement C CFR(s): 483.21(b)(1) §483.21(b) Comprehe §483.21(b)(1) The faci implement a compreh care plan for each res resident rights set fort §483.10(c)(3), that incobjectives and timefra medical, nursing, and needs that are identificant assessment. The comdescribe the following (i) The services that a or maintain the reside physical, mental, and required under §483.2 (ii) Any services that wunder §483.24, §483.3 provided due to the reunder §483.10, includ treatment under §483. (iii) Any specialized serehabilitative services provide as a result of recommendations. If a findings of the PASAR rationale in the resident (iv)In consultation with resident's representati (A) The resident's goad desired outcomes. (B) The resident's prefuture discharge. Facil whether the resident's community was asses	ensive Care Plans comprehensive Care Plans comprehensive Care Plans comprehensive develop and comprehensive person-centered control of the strength of the str		Staff were in-serviced or care plans for resident and also to be aware or care plan updates or checks to determine the plans are being followeresults of the checks with discussed in the Cardinameetings and results submitted to the facility submitted to	#s 33, 14.The the pliance on, and ons. no will vices on to pliance f any nanges. g or her weekly nat care ed. The vill be nal IDT

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
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NAME OF PROVIDER OR SUPPLIER WAYLAND NURSING AND REHABILITATION CENTER		Ĩ	STREET ADDRESS, CITY, STATE, ZIP C 730 LUNENBURG HIGHW KEYSVILLE, VA 23947		06/07/201 <u>9</u>		
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F 656	plan, as appropriate, in requirements set forth section. This REQUIREMENT by: Based on observation document review and was determined the faimplement the compreseven of 33 residents Residents # 33, #34, # #14. 1. The facility staff faile plan for the treatment Resident #33. 2. The facility staff faile plan for the use of psy Resident #34. 3. The facility staff faile plan for pain for Resident #44 the follow the comprehens administration of an are 5. The facility staff faile comprehensive care ploxygen for Resident #46. The facility staff faile comprehensive care ploxygen for Resident #46. The facility staff failed.	the comprehensive care in accordance with the in paragraph (c) of this is not met as evidenced in staff interview, facility clinical record review, it cility staff failed to thensive care plan for in the survey sample, 44, #10, #49, #48, and and and to implement the care of high blood pressure for the dot implement the care chotropic medications for the dot implement the care ent #44. The facility staff failed to ive care plan for the tipsychotic medication. The dot implement the and for the administration of 10. The dot implement the and for the administration of 19.	F 656				

FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			
		405226	P. WING			Ç
NAME OF P	ROVIDER OR SUPPLIER	495226	B. WING	REET ADDRESS, CITY, STATE, ZIP CODE	06/	07/2019
WAYLANI	NURSING AND REHA	BILITATION CENTER	730	LUNENBURG HIGHW YSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 656	Continued From pag	ge 73	F 656			
	comprehensive care oxygen for Resident	plan for the administration of #48.				
	comprehensive care	ailed to implement the plan for the use of tion for Resident #14.				
	The findings include					
		iled to implement the care at of high blood pressure for				
	5/1/19 with diagnose limited to: dementia, diabetes, stroke and pulmonary disease -	COPD (chronic obstructive general term for chronic, sease that is usually a			8	
	assessment, an admassessment reference resident as scoring a interview for mental sis severely impaired decisions. The reside extensive assistance	S (minimum data set) ission assessment, with an the date of 5/8/19, coded the "3" on the BIMS (brief status) score, indication she to make daily cognitive the was coded as requiring to being dependent upon all of her activities of daily				
	documented in part, blood pressure): at ri failure, arterioscleroti	care plan dated, 5/3/19, 'Focus: Hypertension (high sk for complications of renal c disease and/or				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
				<u></u> ,	ħ	С
		495226	B. WING		06	6/07/2019
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		-
WAYLAND	NURSING AND REHAB	ILITATION CENTER	1	730 LUNENBURG HIGHW		
				KEYSVILLE, VA 23947		
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	Continued From page		F 6	56		
	part, "Monitor blood p and/or as ordered by	ressure per facility protocol physician."				
	"Metoprolol Tartrate (pressure) (2), 25 mg (by mouth twice daily.	lated, 5/2/19 documented, used to treat high blood (milligrams) 1/2 = 12.5 mg Hold for SBP (systolic blood 00 or HR (heart rate) less				
5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5	documented the above following dates and time pressure/pulse was not administration of the resolution	me, the following blood ot documented prior to the				

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING		(X3) DATE SURVEY COMPLETED	
	495226	B. WING		C	
NAME OF PROVIDER OR SUPPLIER WAYLAND NURSING AND REHABILITATION CENTER		STRE 730 L	EET ADDRESS, CITY, STATE, ZIP CODE LUNENBURG HIGHW (SVILLE, VA 23947)	06/07/201 <u>9</u>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION	
F 656	Continued From page 75 5/30/19 at 9:00 p.m no pulse or blood pressure was documented. Review of the nurse's notes for the above listed dates and times failed to evidence documentation of the missing blood pressure or pulse. Review of the vital signs tab in the computerized record, failed to evidence the missing pulse or blood pressure readings. An interview was conducted with LPN (licensed practical nurse) #2 on 6/5/19 at 3:29 p.m. LPN #2 was asked to read the above order for Metoprolol. When asked if a resident has that order, what is the nurse to do LPN #2 stated, "You have to take the blood pressure and pulse before giving it." When asked if you have to take both, LPN #2 stated, "I would think so since it asks for both." When asked if the care plan says to give medications as ordered, is that following the care plan, LPN #2 stated, "No." An interview was conducted with administrative staff member (ASM) #2, the director of nursing, on 6/5/19 at 3:36 p.m. Had ASM #2 read the above order. When asked what is the nurse supposed to do, ASM #2 stated, "Take the blood pressure and pulse." When asked why there is no documentation of a pulse or blood pressure on some days, ASM #2 stated, "Well the order does say 'or." .When asked if the care plan says to give medications as ordered, and it's not given as ordered, is that following the care plan, ASM #2 stated, "No, it's not." The facility policy, "Resident Care Plan" documented in part, "It is the policy of the facility to provide a written resident-centered care plan hased upon physician's orders, and the	F 656			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY COMPLETED C	
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	DER OR SUPPLIER RSING AND REHABILITATION CENTER	730 1	EET ADDRESS, CITY, STATE, ZIP CODE UNENBURG HIGHW SVILLE, VA 23947	00/0//2019	
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assipred of the part of the pa	essment of the resident needs and ferencesDevelopment and implementation he resident's care plan will occur by ticipating disciplines available in the facility at eam conference under the director of the RN gistered nurse) Coordinator." M #1, the administrator and ASM #4, the lility nurse consultant, were made aware of the ove findings on 6/6/19 at 7:45 a.m. further information was obtained prior to exit. Barron's Dictionary of Medical Terms for the n-Medical Reader, 5th edition, Rothenberg and apman, page 124. This information was obtained from the owing website: os://medlineplus.gov/druginfo/meds/a682864.h The facility staff failed to implement the care in for the use of psychotropic medications for sident #34. Sident #34 was admitted to the facility on 17/17 with diagnoses that included but were limited to: diabetes, dementia, depression, oke, high blood pressure, and bradycardia (A with heart beat lower than 60 in adults) (1). The most recent MDS (minimum data set) ressment, a quarterly assessment, with an essment reference date of 5/10/19, coded the dident as scoring "3" on the BIMS (brief erview for mental status) score, indicating the dident was severely impaired to make daily guitive decisions. In Section E - Behaviors, the	F 656			

	NT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA N OF CORRECTION IDENTIFICATION NUMBER:	l ` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495226 OF PROVIDER OR SUPPLIER		REET ADDRESS, CITY, STATE, ZIP CODE	C 06/07/201 <u>9</u>
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F 68	Continued From page 77 during the look back period and not indicators of psychosis. The comprehensive care plan dated, 10/22/18 documented in part, "Focus: Problematic manner in which resident acts characterized by ineffective coping; verbal/physical aggression or combativeness related to: anger." The "Interventions" documented in part, "Monitor and document behavior (physical behaviors) per facility protocol." The care plan further documented, "Focus: Problematic manner in which resident acts characterized by ineffective coping; Sleeplessness/insomnia related to: restlessness." The "Interventions" documented in part, "Administer medication. Monitor sleep pattern and quality of sleep/rest, document episodes, and notify physician of changes for possible interventions as appropriate." The care plan documented "Focus: Use of psychoactive drugs with the POTENTIAL FOR or characterized by SIDE EFFECTS of cardiac, neuromuscular, gastrointestinal systems AEB (as exhibited by) or/due to diagnoses of: antipsychotic, antidepressant (GDR [gradual dose reduction] antipsychotic 7/6/18.)" The "Interventions" documented, "Administer medications per physician's orders. Observe resident's mental status functioning on ongoing basis." The review of the clinical record from 12/1/18 through 6/6/19, failed to evidence any documentation related to any physical behavior or sleep patterns. The review of the nurse's notes from 12/1/19 through 6/6/19 documented the following behaviors: "1/25/19 at 2:40 p.m message left for RR	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A, BUILDING			(X3) DATE SURVEY COMPLETED	
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F 656	Continued From page (resident representati	e 78 ve) regarding condition of	F	656			
	the cream however h it to be put on. "2/2/19 at 10:45 p.m., memory loss. Wants	remain dry continuing with e frequently refused to allow Resident has short term to go to bed as soon as he					
	that we are in the mid other residents. Resid minutes later will be d wants to go to bed. W	s to remind him every night Idle of supper ad feeding Ident will say OK, then a few Ident will s				H20	31 . Y
	supper. "2/13/19 at 2:51 p.m. RR about resident restated that she had a	Nurse called and spoke with fusal with shaving. She Iready brought razor up to			æ		
	no BM (bowel moven administer MOM (mill	ere. Resident flagging x 3days ent). Nurse attempted to of magnesia) and resident that.' Resident continues to				¥):	
	taking MOM x3 day d refusal of shower.	RR aware about refusal of /t (due to) no BM and					
	assistant) resident re morning, writer offere "3/15/19 at 10:06 a.m	Per CNA (certified nursing fused to be shaved this and to so still resident refused. In Flagging x3 days no BM.			1		
	refused. "3/30/19 at 8:41 a.m. "4/8/19 at 12:02 p.m.	, Resident refused shower. resident flagging for no BM					
	to be lifted by CNA w supervision.						

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING	COMPLETED		
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NAME OF PROVIDER OR SUPPLIER WAYLAND NURSING AND REHABILITATION CENTER B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947	06/07/201 <u>9</u>		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORR PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	SHOULD BE COMPLETION		
Continued From page 79 x 3 days, resident only accepted 15 cc (cubic centimeters) MOM. *4/22/19 at 11:08 a.m., Resident flagged for no BM x3 days, resident refused to take MOM per protocol. *4/24/19 at 5:52 a.m. Resident flagging for no bowel movement in the past three days. Due to refusal of MOM. *5/15/19 at 5:51 a.m. Resident flagging for no BM x3 days, MOM refused. *5/17/19 at 10:29 a.m. Resident flagging for no BM x 3 days. MOM given but resident would only take apprx (approximately) 15 cc. The physician notes dated 11/26/18, documented in part, "Psych (psychiatric): he is pleasant and understand who I am as the doctor. No other documentation regarding his mood or behaviors. The physician note dated, 12/3/18, failed to evidence documentation related to mood or behaviors. The physician note dated, 4/1/19, failed to evidence any documentation related to mood or behaviors. The nurse practitioner note dated, 12/5/18, documented in part, "Past Medical History - depression. Review of Systems: Psychiatric - no increased nervousness or suicidal ideations. Physical Exam: Psychiatric in oincreased nervousness or suicidal ideations. The nurse practitioner note dated, 2/22/19, documented in part, "Past Medical History - depression. Review of Systems: Psychiatric - no mood swings, increased nervousness or suicidal diestions. Physical Exam: Psychiatric in oincreased nervousness or suicidal ideations. The nurse practitioner note dated, 2/22/19, documented in part, "Past Medical History - depression. Review of Systems: Psychiatric - no mood swings, increased nervousness or suicidal ideations.			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1	(X2) MULTIPLE CONSTRUCTION A. BUILDING			
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F 656	affect pleasant, reside place.	cam: Psychiatric - Mood and ent oriented to person and	F 656			
	compliance with his n (Resident #34) has di irritability, mood swing motivation. She repor medication and coope denies any suicidal id ideationsPast Medi Review of Systems: F cognition or increase	His nurse reports resident nedication and diet epression. His nurse reports gs and decreased ts he is compliant with his erative with his care. He eations or homicidal cal History - Depression. Psychiatric: no changes in d nervousnessPhysical ood and affect flat; resident		45		(F (44) ^{II}
	practical nurse) #2 or asked where behavior stated, on the back or administration record When asked what Respending with the stated, "When he first been cut back. His would have behaviors are plan, Lender asked if document it if she satisfied behavior or something when asked if document asked if document and the country are on the country are on the country are on the country are plan, Lender asked if document if they have asked if they have the country are on the country are plan, Lender asked if document if they have asked if they have the country are plan, Lender asked if document if they have asked if they have the country asked in the country are plan, Lender asked if document if they have asked where the country asked in the country asked in the country asked where they are they ar	ducted with LPN (Licensed of 6/5/19 at 5:43 p.m. When are are documented, LPN #2 of the MAR (medication of the mark (medication of the mark) and in the progress notes." It is ident #34's targeted use of Seroquel, LPN #2 of the mark (medication of the mark (medication of the mark) and the mark (medication of the mark) and the mark (medication of the medication of the mark) and the mark (medication of the medication of the mark) and the mark (medication of the medication of the mark) and the mark (medication of the medication of t				

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F 656	Continued From page	81	F 656		
	of nursing, and ASM a consultant were made concern on 6/6/19 at	aware of the above		<i>ii</i>	
	No further information	was provided prior to exit.			
		of Medical Terms for the 5th edition, Rothenberg and			
	3.a. The facility staff for plan for pain for Resid	ailed to implement the care ent #44.			
	with an assessment recoded the resident as (brief interview for me the resident was capa cognitive decisions. Trequiring extensive as member for most of his Section J - Health Cocoded under J0800 as as having any non-verof pain or facial grima resident was coded as of any pain.	ant change assessment, aference date of 5/16/19, scoring a "14" on the BIMS antal status) score, indicating ble of making daily the resident was coded as sistance of one staff or activities of daily living. In additions, the resident was a not having been observed that signs, vocal complaints cing indicating pain. The sanot having documentation			
	revised on 5/20/19, do Risk for Potential Pair impaired mobility, hx obilateral knees, femur (stroke)." The "Interve "Administer pain mediorders and note the e	are plan dated, 1/16/17 and ocumented in part, "Focus: a, chronic related to history of) osteoarthritis, right arm pain and CVA ntions" documented in part, cation as per MD (doctor) fectiveness. Give PRN (as ations) for breakthrough			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING		(X3) DATE SURVEY COMPLETED		
	495226	B. WING		С		
NAME OF P	ROVIDER OR SUPPLIER		ET ADDRESS, CITY, STATE, ZIP CODE	06/07/2019		
WAYLAND	NURSING AND REHABILITATION CENTER		UNENBURG HIGHW SVILLE, VA 23947			
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F 656	Continued From page 82 pain as per MD orders and note the effectiveness. Monitor and document characteristics of pain: location, severity and frequency, precipitating factors, etc." The physician order dated, 5/15/19, documented, "Ultram (Tramadol) (used to treat moderate to moderately severe pain) (3), 50 mg (milligrams), 1 by mouth three times a day as needed for pain." The May 2019 MAR (medication administration record) documented the above order for Tramadol. The medication was documented as having been administered on the following dates and times: 5/16/19 at 6:00 a.m no effectiveness documented. 5/16/19 at 10:00 p.m no effectiveness documented 5/19/19 at 11:45 p.m no effectiveness documented 5/20/19 at 3:15 p.m medication was helpful 5/21/19 at 2:15 a.m effective 5/27/19 at 4:45 p.m sleeping 5/28/19 at 8:40 a.m effective 5/29/19 at 4:30 p.m effective 5/30/19 at 4:30 p.m effective None of the above documentation documented any pain scale prior to the administration or after the administration of the medication. Review of the nurse's notes for the above dates failed to evidence any documentation of a pain	F 656				
	scale or effectiveness of the medication. Review of the "Pain Level Summary" in the clinical record failed to evidence any level of pain from 5/1/19 through 6/6/19.					

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING	CONSTRUCTION	COMPLETED	
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NAME OF PROVIDER OR SUPPLIER WAYLAND NURSING AND REHABILITATION CENTER		STF	REET ADDRESS, CITY, STATE, ZIP CODE LUNENBURG HIGHW YSVILLE, VA 23947	06/07/201 <u>9</u>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLÉTION	
F 656	Continued From page 83 The May 2019 MAR documented the above order for Tramadol. The medication was documented as having been administered on the following dates and times: 6/3/19 at 6:00 p.m effective. Review of the nurse's notes for the above date failed to evidence any documentation of a pain scale prior to the administration or after the administration of the Tramadol. An interview was conducted with LPN (licensed practical nurse) #3 on 6^19 at 10:31 a.m. When asked the process for when a resident complains of pain, LPN #3 stated, "First you assess the resident, ask the pain scale, and try non-pharmacological interventions like repositioning or distraction. If that is not effective we give the pain medication and then follow up with the resident in 30-60 minutes." When asked where all of that is documented, LPN #3 stated, "It's in the nurse's notes." When asked the purpose of the care plan, LPN #3 stated it's the plan of care for each resident. When asked if it should be followed, LPN #3 stated, "Absolutely." An interview was conducted with LPN #1 on 6/6/19 at 10:35 a.m. When asked the process for when a resident complains of pain, LPN #1 stated, "I evaluate the resident, assess them, ask the pain scale, try non-pharmacological interventions. If that is not effective, I will give the pain medication and follow up with them in 30 minutes to see if it's effective." When asked where the assessment and pain scale is documented, LPN #1 stated, "There is a tab under the vital signs section of the computerized clinical record and we can enter the pain scale there. And you should write a progress note."	F 656			

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F 656	#1 stated it how we gibased on their needs asked if it should be foregreen with the state of the	bese of the care plan, LPN ve care of the resident and preferences. When bllowed, LPN #1 stated, to be reviewed and revised ed." ember (ASM) #1, ASM #2 ty nursing consultant, were ove findings on 6/6/19 at was provided prior to exit. of Medical Terms for the 5th edition, Rothenberg and of Medical Terms for the 5th edition, Rothenberg and	F 656		
	follow the comprehens	he facility staff failed to sive care plan for the ntipsychotic medication.			
	severe major depress symptoms, dementia disorder, anxiety disor high blood pressure, o	ses of but not limited to ion with psychotic with behavior, bipolar der, psychotic disorder, diabetes, and cataracts. (Minimum Data Set) was a			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING		
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F 656	Continued From page	∍ 85	F 656		
	(Assessment Referer resident was coded a ability to make daily li out of a possible 15 of Mental Status) excoded as requiring to extensive care for tra	nce Date) of 5/16/19. The is being cognitively intact in ife decisions, scoring a 14 in the BIMS (Brief Interview am. The resident was	26		
	0.5 mg (milligrams) bi	ed 5/20/19 for Risperdal (1) id (twice daily) prn (as and bipolar. (Note: Anxiety			
	prepare and administ to Resident #44: Zaditor (2) eye drops, Miralax (3) 17 grams Voltaren gel (4), appli Depakote (5) sprinkle 2 tabs Calcium (6) 250mg, w gave 1 tab	ed to both knees 125 mg (milligrams), gave vith Vitamin D3 125 units,			
	At this time she asked needed her "medication resident stated she di appear anxious or aginher wheelchair appear no apparent signs of a did not offer any non-interventions at this timesident's Risperdal fright drawer. As she was p	on for anxiety." The d. The resident did not itated. The resident was in ring very calm. There were anxiety or agitation. LPN #1	((4.0)	·X	9

	F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED
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	resident it was for he with the resident to he medications. She as applied the Voltaren She then assisted the wheelchair and admidrops and then gave pills, including the Rimedications, she the bed. On 6/05/19 at 2:24 Fff, when asked what stated, "anxiety." Wobservation of the reas-needed (prn) antiresident had request anxiousness and had was tired, saying I can When asked if it was stated it was. When order stated it was for show that the Risper When asked about of interventions, she stated agitated earlier about and bunched up and readjusting her clothing the time she met is medication cart at 8:3 medications, the resisions of anxiety or agit the Risperdal without nonpharmacological she had repositioned (in her room with the gel to her knees) and administering all medications and medications all medications and mistering all medications and mistering all medications.	er anxiety. She then went her room to administer the esisted the resident up and gel to the resident's knees. It is resident back into the inistered the Zaditor eye of the resident the cup of the sperdal. After administering on assisted the resident to the sident to the sident being offered an apsychotic, she stated that the led the Risperdal "for the sident being offered an apsychotic, she stated that the led the Risperdal "for the sident being out, saying she and the stay up, and I gotta go." ordered for anxiety, she asked to show where the large and the sident was unable to dal was ordered for anxiety. If the sident was the resident was the resident was the resident at the least that the resident at the least AM, to give her dent was not showing any gitation, and she still offered	F 6	56	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	SE COMPLETION	
F 656	tired. When it was noted that these additional interventions were done only in conjunction with or after providing the medication, and not beforehand and then re-evaluated for effectiveness, she stated the resident had asked for the medication and it was her right to have it. When asked what is the process for determining if a resident needs a PRN medication, she stated that staff should try to figure out why the resident wants the medication, try to fix whatever the situation might be by offering non pharmacological interventions, and give the medication only after other attempts are ineffective. Further review of the clinical record failed to reveal any nurses notes documenting the nature of the resident's anxiety and agitation or any non-pharmacological interventions attempted. A review of the back of the MAR (Medication Administration Record) for June 2019 for Resident #44 revealed the Risperdal was administered for "resident request for	F 656			
	anxiousness." On 6/06/19 at 7:11 PM, in an interview with LPN #4, she stated that Risperdal is an antipsychotic used for aggressive behaviors. She stated that it is not used for anxiety. She stated that she would not give a resident Risperdal if they say they have anxiety. She stated that to give it, there would need to be combative or aggressive behaviors or exhibiting some type of psychotic behaviors. She stated she would not give it if the resident was not showing these symptoms. She stated that the care plan was not followed because the Risperdal was given for the wrong reason. A review of the comprehensive care plan				

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		495226	B. WING			27/2040	
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NAME OF PI	ROVIDER OR SUPPLIER					Í	
WAYLAND	NURSING AND REHABI	LITATION CENTER		730 LUNENBURG HIGHW KEYSVILLE, VA 23947			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 656	resident acts character verbal/ physical Aggrer related to: Cognitive in changes in the brain." 2/8/18. The intervention 2/8/18 for "Monitor an facility protocol" and comedication as prescril and one dated 3/25/19 anxiety per facility prochanges as indicated. dated 6/5/12 document drugs with the potentiaside effects due to use antidepressants, antipedocumented the intervent and manister medication. A review of the facility Plans" did not document be followed. On 6/6/19 at 7:43 PM, Staff Member - the Add Director of Nursing) at Consultant) were notified further information was survey. (1) Risperdal - is an at treat schizophrenia, mepisodes, and behavior information obtained in https://medlineplus.gottml	colematic manner in which prized by ineffective coping: assion or Combativeness impairments/phys (physical). This care plan was dated dons included one dated document behavior per one dated 5/31/18 for "Give bed by MD (medical doctor); 9 for "Document episodes of tocol and notify MD of "In addition, a care plan inted, "Use of psychotropic al for or characterized by so of medications, asychotic." This care plan evention dated 6/5/12 for ins per physician's order." In policy, "Resident Care ent that the care plan must what the care plan must have ministrator), ASM #2 (the ind ASM #4 (Facility Nurse fied of the concerns. No is provided by the end of the intipsychotic and is used to mania, mixed mood ors.	F 656			5:	
	relieve the itching of a						

	OF DEFICIENCIES (X F CORRECTION	1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	COMPLETED
NAME OF PROVIDER OR SUPPLIER WAYLAND NURSING AND REHABILITATION CENTER		B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947	C 06/07/201 <u>9</u>	
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F 656	tml (3) Miralax - is used to the Information obtained from https://medlineplus.gov/etml (4) Voltaren - is a topical from osteoarthritis. Information obtained from https://medlineplus.gov/eml (5) Depakote - is used to bipolar disorder. Information obtained from the image of t	druginfo/meds/a604033.h eat constipation. m druginfo/meds/a603032.h gel used to treat pain m druginfo/meds/a611002.ht treat seizures and m druginfo/meds/a682412.h a mineral found in many calcium to maintain y out many important cium is stored in bones corts their structure and coneeds calcium for merves to carry or nerves to carry or ain and every body is used to help blood ughout the body and to and enzymes that affect the human body. m	F 65		

	OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	ONSTRUCTION	(3)	LETED
		D MINIO			
NAME OF B	495226	B. WING			07/2019
NAME OF P	ROVIDER OR SUPPLIER		EET ADDRESS, CITY, STATE, ZIP COD	E	
WAYLAND	NURSING AND REHABILITATION CENTER		LUNENBURG HIGHW		
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 656	Continued From page 90	F 656			
ra T	5. The facility staff failed to implement the comprehensive care plan for the administration of oxygen for Resident #10.		5	v	
9 2	Resident #10 was admitted to the facility on 2/21/19 with the diagnoses of but not limited to high blood pressure, chronic obstructive pulmonary disease (1), obstructive and reflux uropathy (2), benign prostatic hyperplasia with lower urinary tract symptoms, and retention of urine. The most recent MDS (Minimum Data			TO SERVE	
9	Set), a Significant Change in Status Medicare assessment, with an ARD (Assessment reference date) of 3/18/19, coded the resident as scoring a 9 out of 15 on the BIMS (Brief Interview for Mental Status) score, indicating the Resident had moderate cognitive impairment for daily decision making. The resident required extensive assistance for eating: total care for hygiene, bathing, dressing, toileting, and transfers; and had an indwelling urinary catheter and was occasionally incontinent of bowel.		2		# * E
	On 6/5/19 at 8:44 AM, and at 2:32 PM, it was observed that Resident #10's oxygen flowrate on the oxygen concentrator was set at 3 ½ liters per minute.				
	A review of the clinical record revealed a physician's order dated 6/1/19, that documented in part, "O2 (oxygen) at 3LPM (3 liters per minute) via NC (nasal cannula)"				
	Further review of the clinical record revealed a MAR (medication administration record) that was dated June 2019, which documented in part "O2"			2	

FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA F CORRECTION IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED
NAME OF P	495226	B. WING	EET ADDRESS, CITY, STATE, ZIP CODE	C 06/07/201 <u>9</u>
	D NURSING AND REHABILITATION CENTER	1 730 L	LUNENBURG HIGHW SVILLE, VA 23947	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
F 656	Continued From page 91 at 3LPM via NC" Further review of the clinical record revealed a comprehensive care plan dated 3/12/19, that documented in part, "Potential for or Actual Ineffective Breathing Patter." The comprehensive care plan documented in part, "Interventions" that noted in part, "Oxygen therapy (3L/M) via (NC) as ordered." On 6/6/19 at 12:43 PM an interview was conducted with LPN (Licensed Practical Nurse) #3. When LPN #3 was asked what rate Resident #10's oxygen is to be set at, she stated, "His is three." When LPN #3 was asked if Resident #10 is care planned for oxygen at 3 liters per minute, she stated, "Yes." When LPN #3 was asked if Resident #10's oxygen rate is to be at 3 ½ liters per minute, she stated, "It is not supposed to be at 3 ½." When LPN #3 was asked if Resident #10's oxygen set at the wrong rate is a problem, she stated, "It is not following orders and the care	F 656		
	plan." A review of the facility's policy "Resident Care Plan," with a revision date of 11/13/2017, documented in part, "Baseline care plans will include the instructions needed to provide effective and patient-centered care for residents that meet professional standard of quality care" According to Potter and Perry's, Fundamentals of Nursing, 7th Edition, page 269 states "A written care plan communicates nursing care priorities to other health care professionals. The nursing care plan enhances the continuity of care by listing specific nursing interventions needed to achieve the goals of care. The complete care plan is the blueprint for nursing action. It provides direction			

	F CORRECTION	IDENTIFICATION NUMBER:	1 ` '		CONSTRUCTION	COMP	LETED
		495226	B. WING				07/2019
	ROVIDER OR SUPPLIER	SILITATION CENTER		73	TREET ADDRESS, CITY, STATE, ZIP CODE 30 LUNENBURG HIGHW EYSVILLE, VA 23947	00/	0172013
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F 656	for implementation of for evaluation of the actions." On 6/7/19 at 11:48 A Member) #1, the Adn of the findings. No further findings. No further findings are the findings of the end of the findings of the finding of the findings of the finding of the findings of the fin	the plan plus the framework client's response to nursing M, ASM (Administrative Staff ninistrator, was made aware or ther information was of the survey. The pulmonary disease: It difficult to breath that can breath. This information was bosite: I pov/medlineplus/copd.html. The pulmonary disease: I to difficult to breath that can breath. This information was bosite: I pov/medlineplus/copd.html. This information was the urine to back up and neys. This information was	F	856			
	Resident #49 was ad 4/23/19 with the diag type 2 diabetes mellitheart failure, chronic disease (1), obstructionand retention of urine (Minimum Data Set), assessment, with an date) of 5/28/19, code out of 15 on the BII	plan for the administration of #49. mitted to the facility on noses of but not limited to us, high blood pressure, obstructive pulmonary we and reflux uropathy (2), the most recent MDS					

	F CORRECTION	IDENTIFICATION NUMBER:		S	COMPLETED	
		495226	B. WING		C 06/07/2019	
	ROVIDER OR SUPPLIER D NURSING AND REHAB	ILITATION CENTER	1	STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947	00/0//2019	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT! (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION	
F 656	severe cognitive imparmaking. The resident set up for eating; extending to the property of the set up for eating; extending the property of the set up for eating; extending the property of the set up for eating; had an intervention of the set up at the s	dirment for daily decision required supervision and insive assistance for deting, transfers: total care dwelling urinary catheter incontinent of bowel. and 6/5/19 at 8:36 AM, it sident #49's oxygen in concentrator was set at 2 If record revealed a decision of a concentrator was set at 2 If record revealed a decision of a concentrator was set at 2 If record revealed a decision of a concentration of a conce	F 65			
	liters." When LPN #3 #49's oxygen rate is to minute, how do you ke	b be set at, she stated, "2 was asked if Resident b be set at 2 liters per now where to set the ball, lown on eye level to set it.		41		

	OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA F CORRECTION IDENTIFICATION NUMBER:	(X2) MULTIPLE COI		(X3) DATE SURVEY COMPLETED
	495226	B. WING		C 06/07/2019
NAME OF PROVIDER OR SUPPLIER WAYLAND NURSING AND REHABILITATION CENTER		STRE 730 L KEY S	06/07/2019	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
F 656	Continued From page 94 The ball would be on the 2 line, not below or above it." When LPN #3 was asked if Resident #49's oxygen rate set at the wrong rate is following the care plan, she stated, "Apparently not." A review of the facility's policy "Resident Care	F 656		
e c	Plan" with a revision date of 11/13/2017 that documented in part, "Baseline care plans will include the instructions needed to provide effective and patient-centered care for residents that meet professional standard of quality care" According to Potter and Perry's, Fundamentals of Nursing, 7th Edition, page 269 states "A written care plan communicates nursing care priorities to other health care professionals. The nursing care plan enhances the continuity of care by listing specific nursing interventions needed to achieve the goals of care. The complete care plan is the blueprint for nursing action. It provides direction for implementation of the plan plus the framework for evaluation of the client's response to nursing actions."			
	On 6/7/19 at 11:48 AM, ASM (Administrative Staff Member) #1, the Administrator, was made aware of the findings. No further information was provided by the end of the survey. (1) Chronic obstructive pulmonary disease: Disease that makes it difficult to breath that can lead to shortness of breath. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html. (2) Obstructive and reflux uropathy: Obstructive uropathy is a condition in which the flow of urine is blocked. This causes the urine to back up and injure one or both kidneys. This information was			7.

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495226	B. WING		C	
NAME OF P	ROVIDER OR SUPPLIER	49922U		TREET ADDRESS, CITY, STATE, ZIP (06/07/201 <u>9</u>	
		ADU ITATION CENTER		0 LUNENBURG HIGHW		
WAYLAND	NURSING AND REHA	ADILITATION CENTER	K	EYSVILLE, VA 23947		
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F 656	Continued From pa	ge 95	F 656			
	obtained from the v https://medlineplus	/ebsite: gov/ency/article/000507.htm		*		
		failed to implement the e plan for the administration of the #48.				
	12/18/19 with the d adult failure to thriv pathological fractur intertrochanteric fra most recent MDS (i Quarterly Medicare (Assessment refere the resident as sco (Brief Interview for indicating the Resid impairment for daily resident was indep- extensive assistant total care for toileting	admitted to the facility on lagnoses of but not limited to e, osteoporosis with current e, and displaced acture of right femur. The Minimum Data Set), a assessment, with an ARD ence date) of 5/20/19, coded ring a 3 out of 15 on the BIMS Mental Status) score, dent had severe cognitive or decision making. The endent for eating; required se for hygiene and dressing; and bathing; and was ent of bladder and bowel.				
	observed that Resi the oxygen concen mlnute.	M and 10:24 AM, it was dent #48's oxygen flowrate on trator was set at 3 liters per		9		
	physician's order d	ical record revealed a ated 5/4/19, that documented 2 liters (per minute) via N/C			is .	
		e clinical record revealed a dministration record) that was				

	F CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	PROVIDER OR SUPPLIER D NURSING AND REHABILITATION CENTER	s1 73	REET ADDRESS, CITY, STATE, ZIP CODE ULUNENBURG HIGHW EYSVILLE, VA 23947	06/07/201 <u>9</u>
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLÉTION
F 656	Continued From page 96 dated June 2019, which documented in part, "Oxygen at 2 liters (per minute) via N/C (nasal cannula)" Further review of the clinical record revealed a comprehensive care plan that was dated 12/19/18, that documented in part, "Potential for or Actual Ineffective Breathing Patter" The comprehensive care plan documented in part, "Interventions" that noted in part, "Oxygen therapy (3L) via (NC) as ordered." On 6/6/19 at 12:43 PM an interview was conducted with LPN (Licensed Practical Nurse) #3. When LPN #3 was asked what Resident #48's oxygen rate is to be set at, she stated, "His was 2 too." When LPN #3 was asked if Resident #48's care plan was updated to reflect the current oxygen order, she stated, "Apparently not." A review of the facility's policy "Resident Care Plan" with a revision date of 11/13/2017 that documented in part, "Baseline care plans will include the instructions needed to provide effective and patient-centered care for residents that meet professional standard of quality care" According to Potter and Perry's, Fundamentals of Nursing, 7th Edition, page 269 states "A written care plan communicates nursing care priorities to other health care professionals. The nursing care plan enhances the continuity of care by listing specific nursing interventions needed to achieve the goals of care. The complete care plan is the blueprint for nursing action. It provides direction for implementation of the plan plus the framework for evaluation of the client's response to nursing actions."	F 656		

PRINTED: 06/18/2019 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING C B. WING 495226 06/07/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW WAYLAND NURSING AND REHABILITATION CENTER KEYSVILLE, VA 23947 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL COMPLETION **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 656 Continued From page 97 F 656 On 6/7/19 at 11:48 AM, ASM (Administrative Staff Member) #1, the Administrator, was made aware of the findings. No further information was provided by the end of the survey. 8. The facility staff failed to implement the comprehensive care plan for the use of psychotropic medication for Resident #14. Resident #14 was admitted to the facility on 8/24/18 with the diagnoses of but not limited to dementia without behavioral disturbance, brief psychotic disorder, anxiety disorder, and high blood pressure. The most recent MDS (Minimum Data Set), a Quarterly Medicare assessment, with an ARD (Assessment reference date) of 4/1/19, coded the resident as scoring a 12 out of 15 on the BIMS (Brief Interview for Mental Status) score, indicating the Resident had moderate cognitive impairment for daily decision making. The resident was independent for bathing, transfers, dressing, and toileting; required supervision and set up assistance for eating; and was always continent of bladder and bowel. On 6/4/19 at 11:03 AM, it was observed that Resident #14 exhibited no behaviors while in the dining room.

behaviors while in her room.

On 6/5/19 at 11:43 AM, and 6/6/19 at 9:35 AM, it was observed that Resident #14 exhibited no

On 6/6/19 at 11:06 AM, it was observed that Resident #14 exhibited no behaviors while in her

F 656 Continued From page 98 wheelchair in the halfway. A review of the clinical record revealed nurse's notes dated 4/9/19, which documented in part, "Re-evaluated resident for wandering. Wandering not at risk, removed wander guard bracelet." Review of the clinical record revealed nurse's notes dated 5/8/19 at 3:30 AM, which documented in part, "observed resident resting quietly in bed with eyes closed." Further review of the clinical record revealed no further nurse's notes documenting behaviors. A review of the clinical record revealed a physician's order dated 6/1/19, that documented in part, "Seroquel (1) 12.5 mg for [milligrams) po (by mouth) QHS (every evening at bed time) for insomnia/psychosis" Further review of the clinical record revealed a MAR (medication administration record) that was dated June 2019, which documented in part, "Seroquel 12.5 mg po QHS for insomnia/psychosis" Further review of the clinical record revealed a comprehensive care plan that was dated 8/24/18, that documented in part, "Use of psychotropic drugs with the potential for or characterized by side effects ofAEB (As Evidenced By); or / due to diagnosis of: psychosis, Insomnia, use of anti-psychotic (GDR Seroquel 5/6/19) (Gradual Dose Reduction)." The comprehensive care plan documented in part, "Interventions" that noted in		F CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED	
MAYLAND NURSING AND REHABILITATION CENTER (PAPER) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F 656 Continued From page 98 wheelchair in the hallway. A review of the clinical record revealed nurse's notes dated 4/9/19, which documented in part, "Re-evaluated resident for wanderding. Wandering not at risk, removed wander guard bracelet." Further review of the clinical record revealed no further nurse's notes dated 5/8/19 at 3:30 AM, which documented in part, "observed resident resting quietly in bed with eyes closed." Further review of the clinical record revealed no further nurse's notes dated 4/9/19, that documented in part, "observed resident resting quietly in bed with eyes closed." Further review of the clinical record revealed no further nurse's notes dated 5/8/19 at 3:30 AM, which documented in part, "observed resident resting quietly in bed with eyes closed." Further review of the clinical record revealed a physician's order dated 6/1/19, that documented in part, "Seroquel (1) 12.5 mg (milligrams) po (by mouth) QHS (every evening at bed time) for insomnia/psychosis" Further review of the clinical record revealed a MAR (medication administration record) that was dated June 2019, which documented in part, "Seroquel 12.5 mg po GHS for insomnia/psychosis" Further review of the clinical record revealed a comprehensive care plan that was dated 8/24/18, that documented in part, "use of psychotropic drugs with the potential for or characterized by side effects ofAEB (As Evidenced By): or / due to diagnosis of resychosis, Insomnia, use of anti-psychotic (GDR Seroquel 5/6/19) (Gradual Dose Reduction).* The comprehensive care plan documented in part, "Interventions" that noted in		495226	B. WING			
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F 656 Continued From page 98 wheelchair in the hallway. A review of the clinical record revealed nurse's notes dated 4/9/19, which documented in part, "Re-evaluated resident for wandering, Wandering not at risk, removed wander guard bracelet." Review of the clinical record revealed nurse's notes dated 5/8/19 at 3:30 AM, which documented in part, "observed resident for wandering, wandering in the clinical record revealed nurse's notes dated 5/8/19 at 3:30 AM, which documented in part, "observed resident resting quietly in bed with eyes closed." Further review of the clinical record revealed no further nurse's notes documenting behaviors. A review of the clinical record revealed a physician's order dated 6/1/19, that documented in part, "Seroquel (1) 12.5 mg (millilgrams) po (by mouth) CHS (every evening at bed time) for insomnia/psychosis" Further review of the clinical record revealed a MAR (medication administration record) that was dated June 2019, which documented in part, "Seroquel 12.5 mg po QHS for insomnia/psychosis" Further review of the clinical record revealed a comprehensive care plan that was dated 8/24/18, that documented in part, "Use of psychotropic drugs with the potential for or characterized by side effects ofAEB (As Evidenced By); or / due to diagnosis of; psychosis, Insomnia, use of anti-psychotic (GDR Seroquel 5/6/19) (Gradual Dose Reduction)." The comprehensive care plan documented in part, "Interventions" that noted in			730 1	LUNENBURG HIGHW	00/07/2019	
wheelchair in the hallway. A review of the clinical record revealed nurse's notes dated 4/9/19, which documented in part, "Re-evaluated resident for wandering. Wandering not at risk, removed wander guard bracelet." Review of the clinical record revealed nurse's notes dated 5/6/19 at 3:30 AM, which documented in part, "observed resident resting quietly in bed with eyes closed." Further review of the clinical record revealed no further nurse's notes documenting behaviors. A review of the clinical record revealed a physician's order dated 6/1/19, that documented in part, "Seroquel (1) 12.5 mg (milligrams) po (by mouth) QHS (sever) evening at bed time) for insomnia/psychosis" Further review of the clinical record revealed a MAR (medication administration record) that was dated June 2019, which documented in part, "Seroquel 12.5 mg po QHS for insomnia/psychosis" Further review of the clinical record revealed a comprehensive care plan that was dated 8/24/18, that documented in part, "be of psychotropic drugs with the potential for or characterized by side effects ofAEB (As Evidenced By): or / due to diagnosis of psychosis, insomnia, use of anti-psychotic (GDR Seroquel 56/19) (Gradual Dose Reduction)." The comprehensive care plan documented in part, "Interventions" that noted in	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	to 4 mm	
Dose Reduction)." The comprehensive care plan documented in part, "Interventions" that noted in	F 656	A review of the clinical record revealed nurse's notes dated 4/9/19, which documented in part, "Re-evaluated resident for wandering. Wandering not at risk, removed wander guard bracelet." Review of the clinical record revealed nurse's notes dated 5/8/19 at 3:30 AM, which documented in part, "observed resident resting quietly in bed with eyes closed." Further review of the clinical record revealed no further nurse's notes documenting behaviors. A review of the clinical record revealed a physician's order dated 6/1/19, that documented in part, "Seroquel (1) 12.5 mg (milligrams) po (by mouth) QHS (every evening at bed time) for insomnia/psychosis" Further review of the clinical record revealed a MAR (medication administration record) that was dated June 2019, which documented in part, "Seroquel 12.5 mg po QHS for insomnia/psychosis" Further review of the clinical record revealed a comprehensive care plan that was dated 8/24/18, that documented in part, "Use of psychotropic drugs with the potential for or characterized by side effects ofAEB (As Evidenced By): or / due to diagnosis of: psychosis, Insomnia, use of	F 656			
part, Observe interaction of resident with others		side effects ofAEB (As Evidenced By): or / due to diagnosis of: psychosis, Insomnia, use of anti-psychotic (GDR Seroquel 5/6/19) (Gradual Dose Reduction)." The comprehensive care plan			Ε)	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
	,	495226	B. WING	***************************************		С
		495226			06/	07/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
WAYLAND	NURSING AND REHABI	LITATION CENTER		730 LUNENBURG HIGHW		
				KEYSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 656	or suicidal ideations! Mood and affect pleas person and placePla care reviewed by prov plan of care Further review of the o physician's note dated documented in part, " systemspsychiatric: no changes in cognitio examPsychiatric: Mo patient oriented to person medications and plan provider"	I record revealed a I 12/15/18, whichReview of No increased nervousness Physical examPsychiatric: ant; patient oriented to an: medications and plan of idercontinue with present clinical record revealed a I 12/23/18, whichReview of No increased nervousness onPhysical bod and affect pleasant; son and placePlan: of care reviewed by	F 656			a.
	documented in part, " systemspsychiatric: or suicidal ideationsF Mood and affect pleas	Review of No increased nervousness Physical examPsychiatric: ant; patient oriented to in: medications and plan of				
	physician's note dated in part, "Review of s changes in cognition o nervousnessPhysica	al examPsychiatric: Mood atient oriented to person lications and allergies			×	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495226	B. WING		C	
NAME OF PROVIDER OR SUPPLIER WAYLAND NURSING AND REHABILITATION CENTER			s 7:	TREET ADDRESS, CITY, STATE, ZIP CODE 30 LUNENBURG HIGHW EYSVILLE, VA 23947	06/07/201 <u>9</u>	
(X4) ID PREFIX TAG	(EACH DEFICIENT	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION	
F 656	physician's note date documented in part, dementia. She requ for meals and assist daily living. She enjuactivitiesReview of changes in cognition examPsychiatric: National patient oriented to permedications and plan provider" A review of the clinic dated 11/27/18, a Quassessment, with an documented in part, above; 200: Behavior	clinical record revealed a ed 4/19/19, which "(name of resident) has ires direction from the staff ance with her activities of bys playing bingo and group systemspsychiatric: No or crying spellsPhysical Mood and affect pleasant; erson and placePlan: of care reviewed by all record revealed MDS parterly - modified Medicare ARD of 8/24/18, which "Section E: 100: None of the r not exhibited; 800: Behavior	F 656			
	A review of the clinic dated 1/4/19, a Quarassessment, with an documented in part, above; 200: Behavior not exhibited; 900: B A review of the clinic dated 3/8/19, a Quarwith an ARD of 3/8/1 "Section E: 100: Nor Behavior not exhibited; 900: Behavior dated 4/1/19, a Quarantee and the clinic dated 4/1/19, a Quarantee and the clinic dated 4/1/19, a Quarantee assessment, with an Areview of the clinic dated 4/1/19, a Quarantee assessment, with an Areview of the clinic dated 4/1/19, a Quarantee assessment, with an account of the clinic dated 4/1/19, a Quarantee assessment, with an account of the clinic dated 4/1/19, a Quarantee assessment, with an account of the clinic dated 4/1/19, a Quarantee assessment, with an account of the clinic dated 4/1/19, a Quarantee assessment, with an account of the clinic dated 4/1/19, a Quarantee assessment, with an account of the clinic dated 4/1/19, a Quarantee assessment, with an account of the clinic dated 4/1/19, a Quarantee assessment, with an account of the clinic dated 4/1/19, a Quarantee assessment.	ed; 800: Behavior not vior not exhibited." al record revealed MDS terly Medicare assessment, 9, which documented in part,	*			

PRINTED: 06/18/2019 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 495226 B. WING 06/07/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW WAYLAND NURSING AND REHABILITATION CENTER KEYSVILLE, VA 23947 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) **PREFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 656 Continued From page 101 F 656 Behavior not exhibited; 800: Behavior not exhibited; 900: Behavior not exhibited." On 6/6/19 at 12:43 PM an interview was conducted with LPN (Licensed Practical Nurse) #3. When LPN #3 was asked if Resident #14 receives Seroquel, she stated, "Not on my shift, but I think she does." When LPN #3 was asked if Resident #14 exhibits any behaviors indicating the need for Seroquel, she stated, "She was when she was moved from back here to long term care. She had some behaviors." When LPN #3 was asked when Resident #14 was moved, she stated, "It was in Nov 2018." When LPN #3 was asked if Resident #14 exhibited any behaviors since, she stated, "Maybe one or two and I guess that is why they are decreasing it." When LPN #3 was asked should Resident #14's behaviors be care planned, she stated, "Yes." When LPN #3 was asked where the nurses would document Resident #14's behaviors, she stated, "You would put them in the progress notes under behavior." When LPN #3 was asked should Resident #14's behaviors be documented.

she stated, "Yes." When LPN #3 was asked if there is a problem when behaviors are not documented even when no behaviors are noted, she stated, "Yes." When LPN #3 was asked if it is a problem if no behaviors are documented, she

stated, "Yes, not following the care plan."

A review of the facility's policy "Resident Care Plan" with a revision date of 11/13/2017 that documented in part, "Baseline care plans will include the instructions needed to provide effective and patient-centered care for residents that meet professional standard of quality care ..."

According to Potter and Perry's, Fundamentals of

	CORRECTION CONTROL IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	COMPLETED
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	495226	B. WING		06/07/2019
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			30 LUNENBURG HIGHW	
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/V4) ID	SUMMARY STATEMENT OF DEFICIENCIES			(ME)
(X4) ID PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA	TE DATE
			DEFICIENCY)	
		ĵ		
F 656	Continued From page 102	F 656		
	Nursing, 7th Edition, page 269 states "A written			
	care plan communicates nursing care priorities to			
	other health care professionals. The nursing care			
	plan enhances the continuity of care by listing			
	specific nursing interventions needed to achieve			
	the goals of care. The complete care plan is the			
	blueprint for nursing action. It provides direction			
	for implementation of the plan plus the framework			
	for evaluation of the client's response to nursing			
	actions."			
	On 6/7/19 at 11:48 AM, ASM (Administrative Staff			
	Member) #1, the Administrator, was made aware			
	of the findings. No further information was			
	provided by the end of the survey.		at	
	promoted by the one or the buryoy.			
	(1) "Seroquel (Quetiapine) tablets and			
	extended-release (long-acting) tablets are used to			
	treat the symptoms of schizophrenia (a mental	-		
	illness that causes disturbed or unusual thinking,			
	loss of interest in life, and strong or inappropriate			
	emotions). Quetiapine tablets and	ľ		
	extended-release tablets are also used alone or	-		
	with other medications to treat episodes of mania	<u> </u>	10	
	(frenzied, abnormally excited or irritated mood) or			
	depression in patients with bipolar disorder			
	(manic depressive disorder; a disease that			
	causes episodes of depression, episodes of			
	mania, and other abnormal moods). In addition, quetiapine tablets and extended-release tablets	悉		
	are used with other medications to prevent			
	episodes of mania or depression in patients with			
	bipolar disorder. Quetiapine extended-release			
	tablets are also used along with other			
	medications to treat depression. Quetiapine			
	tablets may be used as part of a treatment			
	program to treat bipolar disorder and			
,	schizophrenia in children and teenagers.			
	Quetiapine is in a class of medications called			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
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		495226	B. WING		06/	07/2019
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
WAYLAND	NURSING AND REHABI	LITATION CENTER	1 7	30 LUNENBURG HIGHW		
			F	KEYSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 656	Continued From page	103	F 656			
		s. It works by changing the	1 000			
		ral substances in the brain."				
		obtained from the website:				
		v/druginfo/meds/a698019.h				
	tml					
F 684	Quality of Care		F 684			
SS=E	CFR(s): 483.25					
	\$ 400.0F O III 6					
	§ 483.25 Quality of ca					
	applies to all treatmen	damental principle that	į,			
		ed on the comprehensive				
		ent, the facility must ensure	(2)			
	that residents receive	treatment and care in				
	accordance with profe	ssional standards of				
		ensive person-centered				
	care plan, and the resi					
		is not met as evidenced				
	by:	ew, facility document review		411		
		ew, it was determined the		(B)		
		isure care and services in				
		ssional standards and the				
		lan for three of 33 residents				
		Residents # 33, #13, #10				
	and #48. The facility st	aff failed to administer				
		nt #33 per the physician's				
		sure a current order for				
		n place for Resident's #13,				
	#10 and #49.					
	The findings include:					
	1. The facility staff faile	ed to administer the		8		
		to the physician order for				
	Resident #33.	a mo prijototati ordor tor				
				5		

PRINTED: 06/18/2019

CENTERS FOR MEDICARE & MEDICAID SERVICES ON	
	MB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X A. BUILDING	(3) DATE SURVEY COMPLETED
495226 B. WING	C
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	06/07/2019
730 LUNENBURG HIGHW	
WAYLAND NURSING AND REHABILITATION CENTER KEYSVILLE, VA 23947	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684 Continued From page 104 F 684 F-684	
Resident #33 was admitted to the facility on	
5/1/19 with diagnoses that included but were not The nurse responsible for	
limited to: dementia, high blood pressure, Resident #33 was in-serviced	
diabetes, stroke and COPD (chronic obstructive regarding the physician order	
pulmonary disease - general term for chronic, pertaining to blood pressure	
nonreversible lung disease that is usually a	
combination of emphysema and chronic bronchitis) (1). medication. Hospice orders medication. Hospice orders were obtained for resident #s	
3	
The most recent MDS (minimum data set)	
assessment, an admission assessment, with an Upon further observation no	
assessment reference date of 5/8/19, coded the	
resident as scoring a "3" on the BIMS (brief	
interview for mental status) score, indication she	
is severely impaired to make daily cognitive decisions. The resident was coded as requiring. The physician orders will be	
decisions. The resident was coded as requiring extensive assistance to being dependent upon reviewed each month to	
one staff member for all of her activities of daily	
living	
are in place. Nursing staff will	
The physician order dated, 5/2/19 documented, be in-serviced as to the	
"Metoprolol Tartrate [used to treat high blood importance of detailed	
pressure (2)], 25 mg (milligrams) 1/2 = 12.5 mg by mouth twice daily. Hold for SBP (systolic blood	
pressure) less than 100 or HR (heart rate) less orders especially when	
than 50." dictated parameters are	
involved.	
Review of the May 2019 MAR (medication	
administration record) documented the above The Director of Nursing or her	
medication order. The medication order. designee will review the	
The medication was not signed off on 5/22/19 at monthly orders to ensure that	
9:00 a.m., 5/23/19 at 9:00 p.m. and 5/26/19 at 9:00 p.m. The reverse side of the MAR failed to the Orders are complete and	\ \ _
evidence documentation as to why the	101119

medication was not given.

Review of the nurse's notes for the above listed dates and times failed to evidence documentation

as to why the medication was not given.

monthly compliance review will be submitted to the

Cardinal IDT members for any

follow -up. Reviews will then

QAPI members for oversight,

PRINTED: 06/18/2019 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING C 495226 B. WING 06/07/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW WAYLAND NURSING AND REHABILITATION CENTER KEYSVILLE, VA 23947 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLÉTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 684 Continued From page 105 F 684 The comprehensive care plan dated, 5/3/19, documented in part, "Focus: Hypertension (high blood pressure): at risk for complications of renal failure, arteriosclerotic disease and/or retinopathy." The "Interventions" documented in part, "Monitor blood pressure per facility protocol and/or as ordered by physician." An interview was conducted with LPN (licensed practical nurse) #2 on 6/5/19 at 3:29 p.m. LPN #2 was asked to read the above order for Metoprolol. When asked what staff should do if a resident has that order, LPN #2 stated, "You have to take the blood pressure and pulse before giving it." When asked what the blank spaces on the MAR were, LPN #2 stated, "It either wasn't done or wasn't signed off." When asked if that is following the physician's orders, LPN #2 stated, "No. Ma'am." An interview was conducted with administrative staff member (ASM) #2, the director of nursing, on 6/5/19 at 3:36 p.m. When asked what the blank spaces on the MAR meant, ASM #2 stated. "Maybe it wasn't done or maybe they forgot to sign it off." The policy "Medication Administration" documented in part, "N. Any deviation from the following principles shall be considered a

medication.

medication error: 1. To the right resident. 2. Administration of the right medication. 3. In the right dose. 4. By the right route. 5. By the right method. 6. At the right time." The policy failed to

document any mention of obtaining the

prescribed vital signs prior to administration of a

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
				==	***	8	С
		495226	B. WING			06/	/07/2019
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
WAYLAND	NURSING AND REH	ABILITATION CENTER	1	730	0 LUNENBURG HIGHW		
		ADDITION OF THE REAL PROPERTY.		KE	EYSVILLE, VA 23947		
(X4) ID PREFIX	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL	ID PREFI)	,	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B	E	(X5) COMPLETION
TAG	REGULATORY (DR LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE
F 684	Continued From pa	age 106	Fé	84			
	ASM #1, the admir	istrator and ASM #4, the					
	facility nurse consu	ıltant, were made aware of the					
	above findings on (6/6/19 at 7:45 a.m.					
		nary of Medical Terms for the					
	Chapman, page 12						
	(2) This information following website:	was obtained from the					
	_	.gov/druginfo/meds/a682864.h					
	tml						
		failed to ensure a current					
	order was in place services to Resider	for the provision of Hospice nt #13					
		admitted on 2/6/15 with the					
	depression chronic	fibrillation, hypothyroidism, cobstructive pulmonary	ľ				
		sorder, intestinal obstruction,					
		tory failure, and neurogenic					
		recent MDS (Minimum Data					
		int change assessment with an					
	ARD (Assessment	Reference Date) of 3/22/19.					
	The resident was c	oded as moderately impaired			2		
		aily life decisions. The					
		as requiring total care for					
		d transfers; extensive					
	assistance for dress	sing; supervision for eating;					
	indwelling catheter	t of bowel and had an					
	mowening cautetet	ioi biaddei.					
		cal record revealed an order					
		Admit to Hospice (name of					
	nospice company) the physician on 3/2	" This order was signed by 20/19.					
	A review of the phys	sician's order sheet (POS) of					
	current orders, for N	May 2019 (signed by the					

	MENT OF HEALTH AND HUMAN SERVICES				NTED: 06/18/201 FORM APPROVEI
	RS FOR MEDICARE & MEDICAID SERVICES			OM	B NO. 0938-039
	OF DEFICIENCIES F CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	PLE CONSTRUCTION		DATE SURVEY COMPLETED
	495226	B. WING			C
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, ST	TATE, ZIP CODE	06/07/201 <u>9</u>
MANA AND MILES OF THE STATE OF		ř	730 LUNENBURG HIGHW		
VVATLANE	NURSING AND REHABILITATION CENTER		KEYSVILLE, VA 23947		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued Farm 107				
1 004		F 68	4		
	physician on 5/4/19), and for June 2019, signed by the physician on 6/1/19, failed to reveal any	91			
	current order in place for the provision of Hospice				
	services.				
	₩				
	Further review of the clinical record revealed the				
	most recent note referring to Hospice, dated				
	5/30/19 at 12:41 PM: "Scheduled care plan				
	meeting invitation mailed to RR (resident				
	representative), and Hospice (name of hospice				
	company)" indicating that the resident was still receiving Hospice services, without a current				
	order.				
	In addition, there was a "Hospice Comprehensive				
	Assessment and Plan of Care Update Report"				
	dated 5/16/19, indicating that the resident was still				
	receiving Hospice after the May 2019, POS was				
	signed on 5/4/19 without a current Hospice order				
	included on the POS.	1			
	On 6/06/19 at 3:05 PM, in an interview with LPN				
	#3, she stated that the resident was still on				
	Hospice. LPN #3 stated that, after reviewing the				
	May 2019 and June 2019 POS, that the resident				
	was getting Hospice without a current order				
	because the physician had signed the POS				
	indicating that those orders were all the current				
	orders and treatments, and that Hospice was not				
	on it.				
	A review of the facility policy, "Hospice Residents"		1		
	did not document that a current physician's order				
	was required for the provision of Hospice				

On 6/6/19 at 7:43 PM, ASM #1 (Administrative Staff Member - the Administrator), ASM #2 (the Director of Nursing) and ASM #4 (Facility Nurse

services.

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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NAMEOFF		495226	B. WING		06/	07/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
WAYLANI	NURSING AND REHAB	ILITATION CENTER		730 LUNENBURG HIGHW		
				KEYSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X6) COMPLETION DATE
F 684	Continued From page	108	F 684	1		
		fied of the concerns. No s provided by the end of the				
	3. The facility staff fail were in place for the p services to Resident #					
	high blood pressure, of pulmonary disease (1) uropathy (2), benign pulmonary tract synurine. The most recer Set), a Significant Charassessment, with an Adate) of 3/18/19, code 9 out of 15 on the BIM Mental Status) score, moderate cognitive immaking. The resident assistance for eating: bathing, dressing, toiled	oses of but not limited to chronic obstructive), obstructive and reflux rostatic hyperplasia with optoms, and retention of at MDS (Minimum Data ange in Status Medicare ARD (Assessment reference d the resident as scoring a S (Brief Interview for indicating the Resident had pairment for daily decision required extensive	÷			
	physician's order for H of April 2019, May 201 A review of the clinical	record revealed a lan dated 3/12/19, which Hospice Care due to				

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	OF DEFICIENCIES F CORRECTION			(X3) DATE SURVEY COMPLETED		
		495226	B. WING			C
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	06/	/07/201 <u>9</u>
1			1901	730 LUNENBURG HIGHW		
WAYLANI	NURSING AND REHAB	ILITATION CENTER		KEYSVILLE, VA 23947		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		0/5)
PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 684	Continued From page	109	F 68	4		
	On 6/6/19 at 3:40 PM	, an interview was				
	conducted with LPN (Licensed Practical Nurse)				
	#3. LPN #3 was aske					
		Care. LPN #3 stated, "Yes."				
		nt #10 has a current order tated, "I don't see one."				
	101 1100p100, El 14 #0 8	dated, Tuon tisee one.				
	On 6/6/19 at 3:50 PM,	LPN #3 presented to the				
	surveyor a handwritter	n order for Hospice Care,				
	dated March 2019.					
	A ravious of the facility	policy "Hooping Desidents "				
		policy "Hospice Residents," of 1/2009, documented in				
	part, "When a resident					
	hospice benefits, the h	nospice agency and the				
		nmunicate, establish, and				
	agree upon a coordina providers"	ated plan of care for both				
	providers					
	Although LPN #3 prov	ided the handwritten order				
	for hospice care, dated	d March 2019, there was no				
	evidence to indicate th					
		r into the physician order				
	and June 2019.	of April 2019, May 2019,				
	and bulle 2019.					
	On 6/7/19 at 11:48 AM	I, ASM (Administrative Staff				
		nistrator, was made aware				
	of the findings.					
	No further information	was provided by the and af				
	the survey.	was provided by the end of				
	vav.j.					
	(1) An indwelling cath	eter is a tube that drains				
	urine from the bladder	to a bag outside of the				
		was obtained from the				
	website:	dana dan dan dan dan da				
	nπps://medilneplus.gov 00140.htm	//ency/patientinstructions/0				

		ID HUMAN SERVICES					APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES					0. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND I DAN OF	CONTROL	I I I I I I I I I I I I I I I I I I I	A. BUILDI	NG _	-		3
		495226	B. WING				07/2019
NAME OF B	ROVIDER OR SUPPLIER	430223			FREET ADDRESS, CITY, STATE, ZIP CODE	00/	01/2010
NAME OF P	ROVIDER OR SUPPLIER		(2)		30 LUNENBURG HIGHW		
WAYLAND	NURSING AND REHAB	ILITATION CENTER			EYSVILLE, VA 23947		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFI	x	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA		COMPLETION DATE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG		DEFICIENCY)	112	
			_				
F 684	Continued From page	a 110	F	684			
	Continuou i ioni pagi						
	(2) Chronic obstruct	ive pulmonary disease:					
		t difficult to breath that can					
		oreath. This information was					
	obtained from the we						
	https://www.nim.nih.g	gov/medlineplus/copd.html.					
	(3) Obstructive and	reflux uropathy: Obstructive					
		on in which the flow of urine					
		es the urine to back up and					
		neys. This information was					
	obtained from the we						
	https://medlineplus.go	ov/ency/article/000507.htm					
		led to ensure orders were in					
		n of Hospice services for					
	Resident #48.						
	Resident #48 was ad	mitted to the facility on					
		gnoses of but not limited to					
		osteoporosis with current					
	pathological fracture,						
	most recent MDS (M	ture of right femur. The					
		ssessment, with an ARD					
		ce date) of 5/20/19, coded					
	the resident as scorir	ng a 3 out of 15 on the BIMS					
	(Brief Interview for M	•					
	_	nt had severe cognitive					
		decision making. The			- E		
		ndent for eating; required for hygiene and dressing;					
		and bathing; and was					
		t of bladder and bowel.					

A review of the clinical record revealed a MDS

PRINTED: 06/18/2019

FORM APPROVED OMB NO. 0938-0391

	F CORRECTION IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495226	B. WING		С
NAME OF P	ROVIDER OR SUPPLIER	0:	STREET ADDRESS, CITY, STATE, ZIP CODE	06/07/201 <u>9</u>
WAYLANI	NURSING AND REHABILITATION CENTER	1 7	30 LUNENBURG HIGHW	
	TOTAL TOTAL STATE OF THE STATE	_P	KEYSVILLE, VA 23947	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 684	Continued From page 111 dated 5/20/19, section O, documented in part, "	F 684	re .	
	Hospice care" the box for "while a resident" was checked.		*	
	A review of the clinical record failed to reveal a physician's order for Hospice care for the month of May 2019.			
	A review of the clinical record revealed a comprehensive care plan dated 12/19/18, which documented in part, " Hospice Care due to disease process"			
	On 6/6/19 at 3:40 PM, an interview with LPN (Licensed Practical Nurse) #3 was conducted. LPN #3 was asked if Resident #10 is currently on Hospice Care. LPN #3 stated, "Yes." When asked if Resident #10 has a current order for Hospice, LPN #3 stated, "I don't see one."			
	On 6/6/19 at 3:50 PM, LPN #3 returned, and stated, "There is no order for Hospice Care."			
-	A review of the facility policy "Hospice Residents," with an effective date of 1/2009, documented in part, "When a resident has also elected the hospice benefits, the hospice agency and the nursing facility will communicate, establish, and agree upon a coordinated plan of care for both providers"			
	On 6/7/19 at 11:48 AM, ASM (Administrative Staff Member) #1, the Administrator, was made aware of the findings. No further information was provided by the end of the survey. Respiratory/Tracheostomy Care and Suctioning	F 695	.*	
	CFR(s): 483.25(i)	F 095		

PRINTED: 06/18/2019 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING Ç 06/07/2019 B. WING 495226 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW WAYLAND NURSING AND REHABILITATION CENTER KEYSVILLE, VA 23947 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID COMPLETION (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F-695 F 695 F 695 Continued From page 112 The oxygen level was adjusted § 483.25(i) Respiratory care, including to the proper flow for tracheostomy care and tracheal suctioning. The facility must ensure that a resident who Residents #10,, 49, 48, and 46. needs respiratory care, including tracheostomy The oxygen Nebulizer for care and tracheal suctioning, is provided such resident #33 was properly care, consistent with professional standards of cleaned and stored. practice, the comprehensive person-centered care plan, the residents' goals and preferences, Other residents requiring and 483.65 of this subpart. This REQUIREMENT is not met as evidenced Oxygen were observed and by: necessary adjustments were Based on observation, staff interview, clinical done. No other nebulizers record review, and facility document review, it was determined the facility staff failed to provide were located. respiratory care and services consistent with Nursing staff will be inprofessional standards of practice, the comprehensive person-centered care plan for five serviced on the proper of 33 sampled residents, (Resident #10, #49, settings of Oxygen and the #48, #46 and Resident #33). The facility staff proper way to observe the failed to administer oxygen according to the physician's orders to Resident's #10, #49, #48, rate of flow per physician and #46, and failed to ensure Resident #33's orders. Each shift will nebulizer mask was stored in a sanitary manner. document through observation that oxygen flow meters are at the proper The findings include: settings, there will be a log 1. The facility staff failed to administer Resident kept at each nurses' station #10's oxygen according to the physician's orders. that will indicate observations and settings. Nebulizers will Resident #10 was admitted to the facility on

FORM CMS-2567(02-99) Previous Versions Obsolete

2/21/19 with the diagnoses of but not limited to

pulmonary disease (1), obstructive and reflux

uropathy (2), benign prostatic hyperplasia with

lower urinary tract symptoms, and retention of urine. The most recent MDS (Minimum Data

Set), a Significant Change in Status Medicare

assessment, with an ARD (Assessment reference

high blood pressure, chronic obstructive

Event ID: 54S511

Facility ID:

cleaned.

Oxygen settings log will be reviewed weekly by the Cardinal IDT members to ensure compliance.

be checked daily for proper

cleanliness and storage. The

bag in which the nebulizer is

kept will be dated to indicate

the latest date checked and

Ion sheet Page 113 of 169

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE O			SURVEY PLETED
		495226	B. WING		1.0	C
	ROVIDER OR SUPPLIER D NURSING AND REHA		STF	REET ADDRESS, CITY, STATE, ZIP C LUNENBURG HIGHW YSVILLE, VA 23947		/07/201 <u>9</u>
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
	9 out of 15 on the BI Mental Status) score moderate cognitive i making. The resider assistance for eating bathing, dressing, to indwelling urinary ca incontinent of bowel. On 6/5/19 at 8:44 AM #10's oxygen flowrat was observed set at minute. A review of the clinic physician's order datin part, "O2 (oxygen) via NC (nasal cannul Further review of the MAR (medication addated June 2019, what 3LPM via NC" Further review of the comprehensive care documented in part, Ineffective Breathing care plan documente noted in part, "Oxyge ordered." On 6/6/19 at 12:43 P conducted with LPN #3. LPN #3 was asker #10's oxygen was ordered."	MS (Brief Interview for a modern indicating the Resident had impairment for daily decision at required extensive and trequired extensive are total care for hygiene, leting, and transfers; had an atheter and was occasionally and the on the oxygen concentrator and a half liters per all record revealed a modern and a half liters per minute) a)" clinical record revealed a ministration record) that was ich documented in part, "O2 clinical record revealed a modern and and and and and and and and and an	F 695			
	is three." When aske	d if Resident #10 was care t 3 liters per minute, LPN #3				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 '	ECONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495226	B. WING			C /07/2019
	ROVIDER OR SUPPLIER NURSING AND REHA	BILITATION CENTER	1 7	TREET ADDRESS, CITY, STATE, ZIP CODE 30 LUNENBURG HIGHW KEYSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
	oxygen rate is to be #3 stated, "It is not sasked what it meand the rate ordered by "It is not following or A review of the facili with a revision date part, " Adjust the flow "It is not following or A review of the facili with a revision date part, " Adjust the flow "According to Fundar edition, Potter and Flow "Oxygen should be to dangerous side effect oxygen toxicity (Tho drug, the dosage or should be continuous should routinely cheverify that the client oxygen concentration medication administration." On 6/7/19 at 11:48 All Member) #1, the Add of the findings. No fiprovided by the end (1) Chronic obstruction Disease that makes lead to shortness of obtained from the wealth the state of	was asked if Resident #10's at 3 ½ liters per minute, LPN supposed to be at 3 ½." When if the oxygen was not set at the physician, LPN #3 stated, ders and the care plan." by's policy "Oxygen Therapy," of April 2017, documented in ow meter to prescribed rate mentals of Nursing, 6th erry, 2005, page 1122, reated as a drug. It has ets, such as atelectasis or mson, 2002). As with any concentration of oxygen sly monitored. The nurse etk the physician's orders to is receiving the prescribed in. The six rights of ration also pertain to oxygen a.M., ASM (Administrative Staff ministrator, was made aware urther information was of the survey. we pulmonary disease: it difficult to breath that can breath. This information was absite: gov/medlineplus/copd.html.	F 695			
8	uropathy is a condition	eflux uropathy: Obstructive on in which the flow of urine ses the urine to back up and		×		

	F CORRECTION	IDENTIFICATION NUMBER:		CONSTRUCTION	COMPLETED
		495226	B, WING		C 06/07/2019
	ROVIDER OR SUPPLIER D NURSING AND REHAE		1 73	TREET ADDRESS, CITY, STATE, ZIP CODE 80 LUNENBURG HIGHW EYSVILLE, VA 23947	00/01/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLÉTION
F 695	injure one or both kid obtained from the we https://medlineplus.go	neys. This information was	F 695		
	#49's oxygen according Resident #49 was ad 4/23/19 with the diagratype 2 diabetes mellitheart failure, chronic disease (1), obstruction and retention of urine (Minimum Data Set), assessment, with an adate) of 5/28/19, code 6 out of 15 on the BIM Mental Status) score, severe cognitive impartmental Status in the resident set up for eating; externing to bathing; had induced was occasionally incommon the set of the set	mitted to the facility on moses of but not limited to us, high blood pressure, obstructive pulmonary or and reflux uropathy (2), and 14-day Medicare ARD (Assessment reference of the resident as scoring and S (Brief Interview for indicating the Resident had airment for daily decision required supervision and msive assistance for letting, transfers: total care celling urinary catheter and intinent of bowel.			
-	Resident #49's oxyge concentrator was obs minute. A review of the clinical physician's order date in part, "O2 (oxygen) NC (nasal cannula) Further review of the MAR (medication adminutes)	at 2L (2 liters per minute) via			

	OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA F CORRECTION IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495226	B. WING		C
NAME OF P	ROVIDER OR SUPPLIER		REET ADDRESS, CITY, STATE, ZIP CODE	06/07/2019
WAYLANI	NURSING AND REHABILITATION CENTER		0 LUNENBURG HIGHW EYSVILLE, VA 23947	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLÉTION
F 695	Continued From page 116 at 2L via NC" Further review of the clinical record revealed a comprehensive care plan, dated 5/9/19, that documented in part, "Potential for or Actual Ineffective Breathing Patter" The comprehensive care plan documented in part, "Interventions" that noted in part, "Oxygen therapy (2L/M) via (NC) as ordered." On 6/6/19 at 12:43 PM, an interview was conducted with LPN (Licensed Practical Nurse) #3. When asked what Resident #49's oxygen flow rate was per the physician order, LPN #3 stated, "2 liters." When asked how staff should set the oxygen flow rate on the oxygen concentrator, LPN #3 stated, "You get down on eye level to set it. The center of the ball would be on the 2 line, not below or above it." When asked what it meant if the oxygen was not set at the rate ordered by the physician, LPN #3 stated, "It is not following orders and the care plan."	F 695		
	A review of the facility's policy "Oxygen Therapy" with a revision date of April 2017, documented in part, "Adjust the flow meter to prescribed rate"			
	According to Fundamentals of Nursing, 6th edition, Potter and Perry, 2005, page 1122, "Oxygen should be treated as a drug. It has dangerous side effects, such as atelectasis or oxygen toxicity (Thomson, 2002). As with any drug, the dosage or concentration of oxygen should be continuously monitored. The nurse should routinely check the physician's orders to verify that the client is receiving the prescribed oxygen concentration. The six rights of			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING				E SURVEY PLETED		
	ROVIDER OR SUPPLIER D NURSING AND REHABI	495226	1 7	STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947	06	C 6/07/201 <u>9</u>
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
100	administration." On 6/7/19 at 11:48 AM Member) #1, the Adm of the findings. No fur provided by the end of the findings are the findings. No fur provided by the end of the findings are the makes it lead to shortness of brobtained from the web https://www.nlm.nih.go (2) Obstructive and refuropathy is a condition is blocked. This cause injure one or both kidn obtained from the web https://medlineplus.go 3. The facility staff falle #48's oxygen accordin Resident #48 was adm 12/18/19 with the diagradult failure to thrive, or	A, ASM (Administrative Staff inistrator, was made aware ther information was if the survey. Depulmonary disease: difficult to breath that can reath. This information was site: by/medlineplus/copd.html. If the urine to back up and the urine to b	F 695			
	pathological fracture, a intertrochanteric fracture most recent MDS (Min Quarterly Medicare as: (Assessment reference the resident as scoring (Brief Interview for Mel Indicating the Resident impairment for daily definite interview for daily daily definite interview for daily daily definite interview for d	and displaced are of right femur. The imum Data Set), a sessment, with an ARD a date) of 5/20/19, coded a 3 out of 15 on the BIMS antal Status) score, t had severe cognitive				

	CORRECTION	IDENTIFICATION NUMBER:	1	E CONSTRUCTION	COMPLETED
		495226	B. WING		C 06/07/2010
	ROVIDER OR SUPPLIER NURSING AND REHAE		5	STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW (EYSVILLE, VA 23947	06/07/201 <u>9</u>
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
F 695	extensive assistance total care for toileting	e 118 for hygiene and dressing; and bathing; and was t of bladder and bowel.	F 695	<u>ē</u>	
		and 10:24 AM, Resident on the oxygen concentrator liters per minute.			
		al record revealed a ed 5/4/19, that documented liters (per minute) via N/C			a .
	MAR (medication adr dated June 2019, whi	clinical record revealed a ninistration record) that was ich documented in part, er minute) via N/C (nasal			
	comprehensive care (12/19/18, that docum or Actual Ineffective E	ented in part, "Potential for Breathing Patter" The plan documented in part, oted in part, "Oxygen			
	#3. When asked what rate was per the physistated, "2 liters." Whiset the oxygen flow raconcentrator, LPN #3 eye level to set it. The on the 2 line, not belowhat it meant if the oxygen was set to be a set of the property of	Licensed Practical Nurse) at Resident #48's oxygen iician's orders, LPN #3 en asked how staff should			

	MENT OF HEALTH AND HUMAN SERVICES			PRINTED: 06/18/2019 FORM APPROVED
STATEMENT	RS FOR MEDICARE & MEDICAID SERVICES OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495226	B. WING		C 06/07/201 <u>9</u>
NAME OF P	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE	¥2.
WAYLAND	D NURSING AND REHABILITATION CENTER	10	730 LUNENBURG HIGHW KEYSVILLE, VA 23947	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 695	following orders and the care plan." A review of the facility's policy "Oxygen Therapy" with a revision date of April 2017, that	F 695	5	
	documented in part, "Adjust the flow meter to prescribed rate" According to Fundamentals of Nursing, 6th edition, Potter and Perry, 2005, page 1122, "Oxygen should be treated as a drug. It has			
	dangerous side effects, such as atelectasis or oxygen toxicity (Thomson, 2002). As with any drug, the dosage or concentration of oxygen should be continuously monitored. The nurse should routinely check the physician's orders to verify that the client is receiving the prescribed oxygen concentration. The six rights of medication administration also pertain to oxygen administration."			
	On 6/7/19 at 11:48 AM, ASM (Administrative Staff Member) #1, the Administrator, was made aware of the findings. No further information was provided by the end of the survey.			
	5. The facility staff failed to store a nebulizer mask in a sanitary manner for Resident #33.			
	Resident #33 was admitted to the facility on 5/1/19 with diagnoses that included but were not limited to: dementia, high blood pressure, diabetes, stroke and COPD (chronic obstructive pulmonary disease - general term for chronic, nonreversible lung disease that is usually a combination of emphysema and chronic			

bronchitis) (1).

The most recent MDS (minimum data set) assessment, an admission assessment, with an

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G	COMPLETED
		495226	B. WING		C
	ROVIDER OR SUPPLIER D NURSING AND REHAB		B. WING_	STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947	06/07/201 <u>9</u>
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLÉTION
F 695	assessment reference resident as scoring a interview for mental stis severely impaired to decisions. The resident extensive assistance one staff member for aliving. Observation was made on 6/4/19 at 2:28 p.m. room. There was a nenightstand uncovered the resident's clothing. An interview was conceptactical nurse) #2 on had just provided the treatment. When asked should be stored when "It's supposed to be in (respiratory equipment containers when not in the mask or cannulas placed in a plastic bag contamination. The coairtight in order to prevent which occurs in a moist facility nurse consultate above findings on 6/6/6/10. No further information	e date of 5/8/19, coded the '3" on the BIMS (brief satus) score, indication she or make daily cognitive in the was coded as requiring to being dependent upon all of her activities of daily e of Resident #33's room The resident was not in the bulizer mask noted on the interest of the control of the contr	F 69	95	

PRINTED: 06/18/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION A. BUILDING _

(X3) DATE SURVEY COMPLETED

495226

B. WING_

С 06/07/2019

NAME OF PROVIDER OR SUPPLIER

WAYLAND NURSING AND REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

730 LUNENBURG HIGHW

KEYSVILLE, VA 23947

WEIGAIREE, AN 40041			METOVILLE, VA 20041	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (XE COMPLIED TO THE APPROPRIATE DATE: DATE:	ETION
F 695	Continued From page 121 Non-Medical Reader, 5th edition, Rothenberg and	F 69	F-697 The nurse in charge of	
	Chapman, page 124.		resident #44 was re-educated	
F 697		F 69	on the proper documentation	
SS=D	CFR(s): 483.25(k)		required for the	
	§483.25(k) Pain Management.		administration of pain	
	The facility must ensure that pain management is			- 1
- 0	provided to residents who require such services,		medication including non-	
	consistent with professional standards of practice,		pharmacological interventions	
	the comprehensive person-centered care plan,		and the necessity of	10
	and the residents' goals and preferences.		documenting the	
	This REQUIREMENT is not met as evidenced		effectiveness of the	
	by:		medication.	
	Based on staff interview, facility document review		medication.	
	and clinical record review, it was determined the		The documentation for other	
	facility staff failed to maintain a comprehensive		residents receiving pain	
	pain management program for one of 33 residents in the survey sample, (Resident #44).			
	The facility staff failed to assess and document a		medication were reviewed	
	pain scale rating when administering as needed		and found to be in	
	pain medication to Resident #44 and failed to	Į.	compliance.	
	document the effectiveness of the medication.			
	I a		Nursing staff will be re-	
	The findings include:		educated on the proper	
			documentation of pain	
	Resident #44 was admitted to the facility on		medications. Residents	
	5/8/12 with a recent readmission on 5/9/19 with		receiving pain medications	
	diagnoses that included but were not limited to: depression, diabetes, dementia, bipolar disorder		will be reviewed weekly by	
	[a mental disorder characterized by episodes of			
	mania and depression (1)], anxiety disorder, high		the DON or her Designee to	
	blood pressure and osteoarthritis [characterized		ensure that proper	
	by degenerative changes in the joints, pain,		documentation is in place.	
	stiffness and swelling can develop after exercise			101
	(2)].		The results of these reviews	nH L
			will be documented on the	$\mathcal{H}_{a,b}$
	The most recent MDS (minimum data set)		pain log in the Cardinal IDT	,
	assessment, a significant change assessment,		meeting room and submitted	
			Facility monthly to the facility's QAPI	
ORM CMS-256	67(02-99) Previous Versions Obsolete Event ID: 54S511	8	Facility Thorntony to the facility 3 QAL 1 nuation sheet Page 122	2 of 169
			COMMITTEE.	

	F CORRECTION IDENTIFICATION			E CONSTRUCTION	COMPLETED
	495	226	B WING		C
NAME OF P	ROVIDER OR SUPPLIER	220		STREET ADDRESS, CITY, STATE, ZIP CODE	06/07/2019
WAYLANI	NURSING AND REHABILITATION CENTER	t		730 LUNENBURG HIGHW KEYSVILLE, VA 23947	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIEN (EACH DEFICIENCY MUST BE PRECEDED REGULATORY OR LSC IDENTIFYING INFO	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLÉTION
F 697	with an assessment reference date of 5 coded the resident as scoring a "14" or (brief interview for mental status) score the resident was capable of making dai cognitive decisions. The resident was requiring extensive assistance of one smember for most of her activities of dai Section J - Health Conditions, the resident was requiring extensive assistance of one smember for most of her activities of dai Section J - Health Conditions, the reside coded under J0800 as not having been as having any non-verbal signs, vocal of pain or facial grimacing indicating paresident was coded as not having documented the above order for the May 2019 MAR (medication admin record) documented the above order for Tramadol. The medication was documented the section of the follow and times: 5/16/19 at 6:00 a.m no effectiveness documented. 5/16/19 at 10:00 p.m no effectiveness documented. 5/16/19 at 3:15 p.m medication was followed the section of the above documentation evid pain scale rating prior to the administration of the medication of the m	a the BIMS , indicating ly coded as taff ly living. In ent was observed complaints in. The mentation cumented, grate to ligrams), 1 for pain." elistration or ented as ring dates senelpful	F 697		

CENTER	RS FOR MEDICARE &	MEDICAID SERVICES			FORM APPROVED
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED
	ROVIDER OR SUPPLIER D NURSING AND REHAE	495226 SILITATION CENTER	B. WINGSTR	EET ADDRESS, CITY, STATE, ZIP CODE LUNENBURG HIGHW YSVILLE, VA 23947	C 06/07/201 <u>9</u>
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
r F	failed to evidence any scale or effectiveness. Review of the "Pain L clinical record failed to from 5/1/19 through 6. The June 2019 MAR order for Tramadol. The documented as admindates and times: 6/3/1 Review of the nurse's failed to evidence any scale prior to the admindering to the The "Pain Assessment documented the reside expression of pain. The documented as having pain scale of 0-10 - terever. It was documented right hip. The resider right hip. The resider caching." What makes resident answered, "me The "Pain Assessment documented the resider expression of pain. The documented as having The "Pain Assessment documented the resider expression of pain. The documented as having The "Pain Assessment documented as having The comprehensive calevised on 5/20/19, doc Risk for Potential Pain,	a notes for the above dates of documentation of a pain of the medication. evel Summary" in the pevidence any level of pain 76/19. documented the above me medication was paintered on the following 9 at 6:00 p.m effective. notes for the above date documentation of a pain painteration or after the framadol. It dated 5/9/19, pent could verbalize be resident was a pain level of "3" on a pain being the worse pain ped the resident's pain is in ent describes the pain as the pain better, the pain better, the pain dated 5/16/19, and could verbalize be resident was a pain level of "0." It dated 5/16/19, and could verbalize be resident was a pain level of "0." The plan dated, 1/16/17 and comented in part, "Focus: chronic related to	F 697		
ir	mpaired mobility, hx (h ilateral knees, femur,	istory of) osteoarthritis, right arm pain and CVA			

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 06/18/2019

		PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	COMPLETED
			5 47140			С
	ROVIDER OR SUPPLIER D NURSING AND REHABILITA	495226 TION CENTER	B. WING	STI	REET ADDRESS, CITY, STATE, ZIP CODE LUNENBURG HIGHW SYSVILLE, VA 23947	06/07/201 <u>9</u>
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	ENT OF DEFICIENCIES IT BE PRECEDED BY FULL ENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION
F 697	Continued From page 124 (stroke)." The "Interventio "Administer pain medication orders and note the effect needed) meds (medication pain as per MD orders and Monitor and document chalocation, severity and frequencial nurse) #3 on 6/6, asked about the process scomplaints of pain, LPN # assess the resident, ask the non-pharmacological interrepositioning or distraction we give the pain medication with the resident in 30-60 where all of that information #3 stated, "It's in the nurse An interview was conducted 6/6/19 at 10:35 a.m. When process staff follows for repain, LPN #1 stated, "I evant assess them, ask the pain non-pharmacological intereffective, I will give the paup with them in 30 minute When asked where the asscale is documented, LPN tab under the vital signs scomputerized clinical recopain scale there. And you note." The facility policy, "Pain Merocedure" failed to evide the administration of as near the state of the sta	ns" documented in part, on as per MD (doctor) veness. Give PRN (as ns) for breakthrough of not the effectiveness. aracteristics of pain: uency, precipitating at 10:31 a.m. When staff follows for resident a stated, "First you ne pain scale, and try ventions like on and then follow up minutes." When asked on is documented, LPN is notes." The d with LPN #1 on a sked about the sident complaints of aluate the resident, scale, try ventions. If that is not n medication and follow is to see if it's effective." sessment and pain #1 stated, "There is a section of the rd and we can enter the should write a progress anagement Policy and noe anything related to	F	697		

	F CORRECTION (X1) PROVIDER/SUPPLIER/CLIA	A. BUILDING		COMPLETED
	*			C
	495226 ROVIDER OR SUPPLIER D NURSING AND REHABILITATION CENTER	730 1	EET ADDRESS, CITY, STATE, ZIP CODE LUNENBURG HIGHW SVILLE, VA 23947	06/07/201 <u>9</u>
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION
F 697	Continued From page 125 the documentation of the pain scale. Administrative staff member (ASM) #1, ASM #2 and ASM #4, the facility nursing consultant, were made aware of the above findings on 6/6/19 at 7:35 p.m.	F 697	fit of the second secon	8
F 756 SS=E	No further information was provided prior to exit. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 33. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 422. (3) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a695011.ht ml Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.	F 756		72
16	§483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist			

PRINTED: 06/18/2019 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE : COMPI	
2		495226	B. WING			06/0	07/201 <u>9</u>
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
WAYLAND	NURSING AND REHAB	ILITATION CENTER		K	EYSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 756	Continued From page	126	F	756	F756		
	_	st be documented on a			The pharmacy	*	
	separate, written repo	nt that is sent to the nd the facility's medical	100		recommendations for		
		of nursing and lists, at a			Residents# 44, 41 25, 11, and		
		t's name, the relevant drug,			8 were completed and signed		
		e pharmacist identified. sician must document in the			by the physician.		
	resident's medical rec				The facility will adopt a		
	•	reviewed and what, if any,			The facility will adopt a		
		to address it. If there is to			specific policy requiring that		
		nedication, the attending			pharmacy recommendations		
	the resident's medical	ument his or her rationale in			will be followed up within 30		
	tile resident a medical	riecord.			days from the time of receipt.		
	§483.45(c)(5) The fac	ility must develop and			This policy will be reviewed		
		procedures for the monthly			and signed by the facility,		
		hat include, but are not			Medical Director and		04
	-	s for the different steps in			consulting Pharmacist.		
		s the pharmacist must take			consuming Filantifiacist.		
		fies an irregularity that			An in-service education will be		
		to protect the resident. is not met as evidenced			conducted with the DON and	ı	
	by:	is not met as evidenced			her administrative staff to		
		n, staff interviews and facility	1				
		as determined that the			ensure compliance with this		
	facility staff failed to d	•	1		new policy		
		that included time frames			Documentation of compliance		
	to address recommen				will be recorded in the		
	pharmacist to the phy	y sample; Residents #41,					
		3. The facility staff failed to	10		resident's chart and reviewed		
		egimen Review policy	±1		by the consulting pharmacist		
	-	in which the physician was			each month.		
	to act upon any pharm	nacy recommendations for					
	Resident's #44, #41,	#25, #11, and #8.					
*	The findings include:						7/21/19
	1. Resident #44 was	admitted to the facility on					M

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S COMPL	
			A. BOILDING _		C	
		495226	B. WING		06/0	7/2019
NAME OF P	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
10/03// 03/0			73	0 LUNENBURG HIGHW		
WAYLANI	NURSING AND REHAB	ILITATION CENTER	K	EYSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 756	Continued From page	e 127 oses of but not limited to	F 756			
	severe major depress symptoms, dementia disorder, anxiety diso high blood pressure, o	ion with psychotic			^	
	significant change ass (Assessment Referen resident was coded a ability to make daily li	sessment with an ARD see Date) of 5/16/19. The s being cognitively intact in fe decisions, scoring a 14 n the BIMS (Brief Interview		32 #		
	recommendation date of the dose of Buspar three times daily to 2.	record revealed a pharmacy of 2/28/19 for the reduction (1) from 5 mg (milligrams) 5 mg three times daily. The with this recommendation 9.				
	recommendation date	_				,
		sibilities" failed to reveal any in which the physician must		· ·		
	Staff Member - the Ad Director of Nursing) a Consultant) were notified regarding the policy n which the physician is pharmacy recommend	ot specifying a time frame in				

	CORRECTION (X1) PROVIDER/SUPPLIER/GLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
	495226	B. WING			07/2019
	NURSING AND REHABILITATION CENTER	I 73	TREET ADDRESS, CITY, STATE, ZIP CODE 30 LUNENBURG HIGHW EYSVILLE, VA 23947	33,	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE
F 756	Continued From page 128 6/7/19 at 8:00 AM, ASM #4 stated that the facility does not have any other policies on the matter. She reviewed the policy that was provided and stated that it did not specify required time frames. (1) Buspar - is used to treat anxiety disorder. Information obtained from https://medlineplus.gov/druginfo/meds/a688005.h tml (2) Protonix - is used to treat gastroesophageal reflux. Information obtained from https://medlineplus.gov/druginfo/meds/a601246.h tml	F 756			
	2. Resident #41 was admitted to the facility on 7/10/18 with the diagnoses of but not limited to acute respiratory failure, diabetes, high blood pressure, anxiety disorder, breast cancer, bladder disorder, atrial fibrillation, congestive heart failure, chronic obstructive pulmonary disease, depression, and osteoporosis. The most recent MDS (Minimum Data Set) was a significant change assessment with an ARD (Assessment Reference Date) of 5/3/19. The resident was coded as being moderately impaired in ability to make daily life decisions. Review of the clinical record revealed a pharmacy recommendation dated 2/26/19 for the reduction of the use of Paxil (1) from 20 mg (milligrams) daily to 10 mg daily. The physician agreed and signed it on 3/8/19.				
	Review of the clinical record revealed a pharmacy recommendation dated 12/26/18 for the cessation				

		ND HUMAN SERVICES MEDICAID SERVICES			FORM): 06/18/2019 APPROVED 0. 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	E CONSTRUCTION	(X3) DATE	SURVEY LETED
		495226	B. WING		06/0	3 07/2019
	ROVIDER OR SUPPLIER NURSING AND REHAE	BILITATION CENTER	ĵ 7	STREET ADDRESS, CITY, STATE, ZIP CODE 30 LUNENBURG HIGHW (EYSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 756	of Vitamin C (2) (dos recommendation dod wound healing, has to could the Vit C be sto agreed and signed it. A review of the facility Pharmacist's Response act upon pharmacy recommendation of Nursing) a Consultant) were not regarding the policy and see with the policy of the reviewed the revie	e not provided). The sumented, "If this was for he wound resolved and opped?" The physician on 1/2/19. If policy, "Consultant sibilities" failed to reveal any in which the physician must ecommendations. If ASM #1 (Administrative diministrator), ASM #2 (the and ASM #4 (Facility Nurse lifed of the concerns not specifying a time frame in its required to act upon dations. ASM #4 stated she what else they have. On SM #4 stated that the facility her policies on the matter. icy that was provided and pecify required time frames. Treat depression, panic try disorder, generalized it traumatic stress disorder, co disorder, and hot flashes	F 756			

Information obtained from

https://medlineplus.gov/vitaminc.html

(2) Vitamin C - is an antioxidant. It is important for your skin, bones, and connective tissue. It promotes healing and helps the body absorb iron.

tml

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	PLE CONSTRUCTION G		(X3) DATE COMF	SURVEY
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		495226	B. WING			06/	07/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STAT	E, ZIP CODE		-
MANAGE A NUM	NUIDOINO AND DELLAD		300	730 LUNENBURG HIGHW			
WAYLANL	NURSING AND REHAB	ILITATION CENTER		KEYSVILLE, VA 23947			
(X4) ID		ATEMENT OF DEFICIENCIES	ID		AN OF CORRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENC	VE ACTION SHOULD BE ED TO THE APPROPRIA FICIENCY)		COMPLETION DATE
F 756	Continued From page	÷ 130	F 7	56			
	7/30/18 with the diagra congestive heart failur blood pressure, fracture dementia, depression osteoarthritis. The mode of the congestive heart failure blood pressure, fracture dementia, depression osteoarthritis. The mode of the assessment Research as a congestion of the resident was code in ability to make daily recommendation date of the dose of Protonism daily. They physic recommendation and A review of the facility Pharmacist's Responsible of the facility Pharmacist's Responsible of the facility Pharmacist's Responsible of the facility Pharmacy of the facility Pharmacy of the facility Pharmacy from the f	pulmonary embolism, and ost recent MDS (Minimum usual assessment with an ofference Date) of 5/26/19. ed as moderately impaired vilfe decisions. record revealed a pharmacy of 4/26/19 for the reduction of x (1) from 40 mg daily to 20 cian agreed with this signed it on 5/4/19. policy, "Consultant sibilities" failed to reveal any in which the physician must commendations. ASM #1 (Administrative ministrator), ASM #2 (the off ASM #4 (Facility Nurse off specifying a time frame in required to act upon dations. ASM #4 stated she hat else they have. On the M#4 stated that the facility per policies on the matter. Cy that was provided and		28			
		ecify required time frames. o treat gastroesophageal					
				_/			

PRINTED: 06/18/2019 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING C B. WING 495226 06/07/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW WAYLAND NURSING AND REHABILITATION CENTER **KEYSVILLE, VA 23947** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL COMPLÉTION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) Continued From page 131 F 756 reflux. Information obtained from https://medlineplus.gov/druginfo/meds/a601246.h tml 4. Resident #11 was admitted to the facility on 1/29/19 with the diagnoses of but not limited to congestive heart failure, urinary retention, chronic kidney disease, gout, spinal stenosis, rhabdomyolysis, syncope, implanted cardiac defibrillator, contractures of bilateral knees, prostate disorder, and uropathy reflux. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 6/3/19. The resident was coded as being severely impaired in ability to make daily life decisions. Review of the clinical record revealed a pharmacy recommendation dated 3/28/19 that documented that Resident #11 was getting Benadryl (1) 25 mg (milligrams) every night at bedtime for insomnia. The recommendation documented, "If the use of

for this resident. Will continue to monitor the

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	E CONSTRUCTION	(X3) DATE COMF	SURVEY
NAME OF B		495226	B. WING			C 07/201 <u>9</u>
	ROVIDER OR SUPPLIER NURSING AND REHABI	LITATION CENTER	1	STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	The physician chose of "#1 applies." The phy recommendation on 4. Further review of the opharmacy recommendation on 4. Further review of the opharmacy recommend documented, "The indunclear from the limite consider updating chaindication(s) or discontional longer required. Colace Neurontin (3) Indication documented, "constipated to the Neurontin and signal 3/8/19. A review of the facility Pharmacist's Responsisted time frames in act upon pharmacy recommending the policy nowhich the physician is pharmacy recommend will look and see what at 8:00 AM, ASM #4 st not have any other policy and the physician is pharmacy recommend will look and see what at 8:00 AM, ASM #4 st not have any other policy and the	B. Discontinue medication at below." Spition 1 and documented, sician signed this (6/19. Simical record revealed a fation dated 2/27/19 that location(s) for use are dochart records. Please records with supporting tinue medication(s) if no see (2) Indication: ——." The physician fation" on the line for the Ineuropathy" on the line for the Ineuropathy" on the line for feed the recommendation on the physician must commendations. ASM #1 (Administrative ministrator), ASM #2 (the did ASM #4 (Facility Nurse ed of the concerns of specifying a time frame in required to act upon fations. ASM #4 stated she else they have. On 6/7/19 ated that the facility does cies on the matter. She at was provided and noted	F 756			

		ND HUMAN SERVICES				บธ/าช/201 APPROVEI
17	S FOR MEDICARE & OF DEFICIENCIES	MEDICAID SERVICES	T 2/2/ 1 11 1 1 1 1		OMB NO.	-
	CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE S COMPLE	
l'		405000	D. WING		С	
NAME OF P	ROVIDER OR SUPPLIER	495226	B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE	06/0	7/2019
WAY! AND	NURSING AND REHAB	NI ITATION CENTER	f	730 LUNENBURG HIGHW		
WATLAND	NORSING AND REHAB	SILITATION CENTER		KEYSVILLE, VA 23947	141	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 756	Continued From page	a 133	F 75	6		
	. •	I to relieve red, irritated,	173	0		
	itchy, watery eyes; sr	neezing; and runny nose				
		allergies, or the common relieve cough caused by				
		/ irritationis also used to				
	prevent and treat mot	tion sickness, and to treat				
		ed to control abnormal				
	parkinsonian syndron	who have early stage				
	Information obtained	from				
	https://medlineplus.go tml	ov/druginfo/meds/a682539.h				
	(2) Colace - is used to					
	Information obtained t	from ov/druginfo/meds/a601113.ht				
	ml	ov/druginio/meds/a601113.nt				
	(3) Neurontin - is used	•				
	neuralgia, restless leg	syndrome, diabetic es related to the treatment				
	of breast cancer or re	lated to menopause.				
	Information obtained t	from		N.		
	https://medlineplus.go	ov/druginfo/meds/a694007.h				
		dmitted to the facility on				
		noses of but not limited to				
		nemiplegia, heart failure, respiratory failure, arthritis,				
	chronic kidney diseas	e, high blood pressure,				
	diabetes, depression,					

disease, morbid obesity, and dysphagia. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 3/12/19. The resident was coded as being moderately impaired in ability to

	OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	DNSTRUCTION	(X3) DATE SURVEY COMPLETED
	495226	B. WING		C
	ROVIDER OR SUPPLIER D NURSING AND REHABILITATION CENTER	STRE	EET ADDRESS, CITY, STATE, ZIP CODE LUNENBURG HIGHW (SVILLE, VA 23947	06/07/201 <u>9</u>
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLETION
F 756	Continued From page 134 make daily life decisions. Review of the clinical record revealed a pharmacy recommendation dated 3/27/19 requesting a registered dietician consult. The physician documented that one bad been obtained as well as weekly monitoring. The physician signed this recommendation on 4/6/19. Review of the clinical record revealed a pharmacy recommendation dated 12/26/18 requesting a registered dietician consult. The physician agreed and signed this recommendation on 1/2/19. (See above recommendation as well.) Review of the clinical record revealed a pharmacy recommendation dated 12/26/18 for the reduction of Zoloft (1) from 75 mg (milligrams) daily to 50 mg daily. The physician agreed and signed this recommendation on 1/2/19. Review of the clinical record revealed a pharmacy recommendation dated 12/26/18 for the cessation of Vitamin C (2). The recommendation documented, "If this was for wound healing, has the wound resolved and could the Vit C be stopped?" The physician agreed and signed this recommendation on 1/2/19. A review of the facility policy, "Consultant Pharmacist's Responsibilities" failed to reveal any specified time frames in which the physician must act upon pharmacy recommendations. On 6/6/19 at 7:43 PM, ASM #1 (Administrative Staff Member - the Administrator), ASM #2 (the	F 756		
	Director of Nursing) and ASM #4 (Facility Nurse Consultant) were notified of the concerns regarding the policy not specifying a time frame in			

AND PLAN OF	FCORRECTION	IDENTIFICATION NUMBER:	1	E CONSTRUCTION	COMPLETED	
		40200			С	
NAME OF P	ROVIDER OR SUPPLIER	495226	B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE	06/07/2019	
WAYLANI	NURSING AND REHABIL	ITATION CENTER	730 LUNENBURG HIGHW KEYSVILLE, VA 23947			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOUNDERSON OF THE APPROPRIES OF	JLD BE COMPLETION	
F 756	would look and see wh 6/7/19 at 8:00 AM, ASM does not have any other She reviewed the policy noted that it did not specific	required to act upon ations. ASM #4 stated she at else they have. On M #4 stated that the facility or policies on the matter. It was provided and ecify required time frames. The eat depression, panic disorder, disorder, generalized raumatic stress disorder, oric disorder.	F 756		×	
SS=D	your skin, bones, and opromotes healing and hard Information obtained from https://medlineplus.gov/Drug Regimen is Free for CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessal Each resident's drug reunnecessary drugs. Andrug when used-§483.45(d)(1) In excess duplicate drug therapy) §483.45(d)(2) For exces§483.45(d)(3) Without a	nelps the body absorb iron. In the body abs	F 757			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
			•			c
		495226	B. WING		06/	07/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
WAY! AND	NURSING AND REHABI	LITATION CENTER	Ŧ	730 LUNENBURG HIGHW		
WAILAND	MOROMO AND REMAD	LITATION OF THE C		KEYSVILLE, VA 23947	L.	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		(X6) COMPLETION DATE
				F-757 —		
			(4)			
F 757	Continued From page	136	F 75	The charge nurse for resident		
	use; or			#33 was re-educated on the		
	§483.45(d)(5) In the p	reserves of adverse		current physician order and		
8 2		ndicate the dose should be		the necessity to monitor and		
	reduced or discontinue			record the blood pressure and		
				pulse of Resident #33 prior to		25
		nbinations of the reasons		the administration of blood		
		d)(1) through (5) of this		pressure medication.		
	section.	is not met as evidenced		pressure medication.		
	by:	is not met as evidenced		Resident #33 was found to be		
	•	ew, facility document review		the only resident that was out		
		iew, it was determined the		of compliance with the order		
		nsure one of 33 residents in		involving blood pressure		
	the survey sample was	•		medication		
	to monitor the resident	#33. The facility staff failed		medication		
	pulse prior to the admi			Nursing staff will be re-		
	pressure medication for			educated on the necessity of		
				following physician orders		
	The findings include:			especially when the order		
	Dosidont #22 was adm	sitted to the facility on		gives specific parameters.		
-	Resident #33 was adm 5/1/19 with diagnoses	that included but were not		gives specific parameters.		
	limited to: dementia, hi			The DON or her designee will		
	· ·	OPD (chronic obstructive		review the documentation		
		eneral term for chronic,		weekly on those residents		
	nonreversible lung disc		2	specifically having orders with		
	combination of emphysbronchitis) (1).	sema and chronic		specific parameters to ensure		
	bronchius) (1).	~				
	The most recent MDS	(minimum data set)		continued compliance. Results		
		sion assessment, with an		of these reviews will be		
		date of 5/8/19, coded the		submitted to the Cardinal IDT		s 1
	resident as scoring a "			members for oversight and		1 10
		atus) score, indication she		review. The QAPI committee		0/2/1/7
	is severely impaired to decisions.	make dally cognitive		will incorporate any findings		1/02/
	acololol la.			of non-compliance and make		

FORM APPROVED OMB NO. 0938-0391

ENTIFICATION NUMBER:	A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
405226	B WING	78	С
495220	B. WING	OTDEET ADDRESS OITY STATE ZID O	06/07/2019
			ODE
ION CENTER		KEYSVILLE, VA 23947	
BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE COMPLETION DATE
	F 75	7	
o treat high blood rams) 1/2 = 12.5 mg or SBP (systolic blood			
sician's medication is and time, the blood umented prior to the ation to Resident #33: se was documented se was documented lse or blood pressure lood pressure or pulse lood pressure or pulse lse was documented			
	495226 ION CENTER IT OF DEFICIENCIES BE PRECEDED BY FULL NTIFYING INFORMATION) 5/2/19 documented, o treat high blood rams) 1/2 = 12.5 mg for SBP (systolic blood HR (heart rate) less administration record) sician's medication as and time, the blood dumented prior to the ation to Resident #33: se was documented alse was do	## A BUILDING ## A SOLUTION ## A S	A 95226 B. WING STREET ADDRESS, CITY, STATE, ZIP C 730 LUNENBURG HIGHW KEYSVILLE, VA 23947 TAG PREFIX TOF DEFICIENCIES BE PRECEDED BY FULL NTIFYING INFORMATION) F 757 5/2/19 documented, to treat high blood trams) 1/2 = 12.5 mg for SBP (systolic blood HR (heart rate) less administration record) sician's medication as and time, the blood tumented prior to the ation to Resident #33: se was documented alse was docume

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED
		495226	B. WING		C 06/07/2019
NAME OF PROVIDER OR SUPPLIER WAYLAND NURSING AND REHABILITATION CENTER		730	EET ADDRESS, CITY, STATE, ZIP CODE LUNENBURG HIGHW YSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION
F 757	dates and times failed of the missing blood p the vital signs tab in the failed to evidence the pressure readings. The comprehensive condocumented in part, "I blood pressure): at ris failure, arteriosclerotic retinopathy." The "Interpart, "Monitor blood pressure by part, "I blood pressure by part, "I blood pressure by part, "I blood pressure): The "Interpart, "Monitor blood pressure by part, "I	notes for the above listed to evidence documentation ressure or pulse. Review of e computerized record, missing pulse or blood are plan dated, 5/3/19, Focus: Hypertension (high of for complications of renal disease and/or rventions" documented in essure per facility protocol	F 757	DEFICIENCY	
	for Metoprolol. LPN #2 should do if a resident stated, "You have to ta pulse before giving it." take both, LPN #2 statit asks for both." An interview was cond staff member (ASM) # on 6/5/19 at 3:36 p.m. physician's order. When nursing staff should do blood pressure and puthere is no documental	was asked what staff has this order. LPN #2 lke the blood pressure and When asked if you have to ed, "I would think so since ucted with administrative 2, the director of nursing; ASM #2 read the above en asked what is the o, ASM #2 stated, "Take the lse." When asked why tion of a pulse or blood			
	order does say 'or." The policy "Medication	I. Any deviation from the all be considered a			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
-		495226	B. WING			07/201 <u>9</u>
NAME OF PROVIDER OR SUPPLIER WAYLAND NURSING AND REHABILITATION CENTER			1 7	TREET ADDRESS, CITY, STATE, ZIP CODE 30 LUNENBURG HIGHW (EYSVILLE, VA 23947	÷	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	SHOULD BE	
F 757	right dose. 4. By the rimethod. 6. At the right document any mention prescribed vital signs medication.	right medication. 3. In the ight route. 5. By the right time." The policy failed to n of obtaining the prior to administration of a	F 757			
er.	doctor may ask you to rate). Ask your pharm how to take your pulse slower than it should to ASM #1, the administr facility nurse consulta above findings on 6/6	nt, were made aware of the				
F 758 SS=E	Non-Medical Reader, Chapman, page 124. (2) This information w following website: https://medlineplus.go tml. Free from Unnec Psyc CFR(s): 483.45(c)(3)(§483.45(e) Psychotro §483.45(c)(3) A psych affects brain activities	chotropic Meds/PRN Use e)(1)-(5) pic Drugs. notropic drug is any drug that associated with mental ior. These drugs include,	F 758		×	

		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 06/18/2019 FORM APPROVED OMB NO. 0938-0391
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
WAYLAND (X4) ID		ATEMENT OF DEFICIENCIES	S 73 K	TREET ADDRESS, CITY, STATE, ZIP CODE 30 LUNENBURG HIGHW EYSVILLE, VA 23947 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	
F 758	resident, the facility in §483.45(e)(1) Reside psychotropic drugs a unless the medication specific condition as in the clinical record; §483.45(e)(2) Reside drugs receive gradual behavioral interventic contraindicated, in an drugs; §483.45(e)(3) Reside psychotropic drugs punless that medication diagnosed specific coin the clinical record; §483.45(e)(4) PRN of are limited to 14 days §483.45(e)(5), if the sprescribing practition	ensive assessment of a nust ensure that ents who have not used re not given these drugs in is necessary to treat a diagnosed and documented ents who use psychotropic il dose reductions, and ens, unless clinically in effort to discontinue these ents do not receive ursuant to a PRN order en is necessary to treat a condition that is documented and enders for psychotropic drugs is. Except as provided in attending physician or	F 758	F-758 The Nursing staff was reeducated on the physician orders, necessity of documentation, and requirements for identifications of targeted behaviors on Residents #44 and 34. No other residents were identified as being out of compliance with documentation. A review of policy and procedures for PRN medications and documentation requirement will be conducted. Staff will then receive education regarding PRN documentation and the proper areas to	

beyond 14 days, he or she should document their rationale in the resident's medical record and

indicate the duration for the PRN order.

§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be

renewed unless the attending physician or prescribing practitioner evaluates the resident for

the appropriateness of that medication.

document targeted behaviors.

Gradual Dose Reductions and

physician documentation of continued medication usage

will be covered.

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING C B. WING 06/07/2019 495226 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 730 LUNENBURG HIGHW WAYLAND NURSING AND REHABILITATION CENTER KEYSVILLE, VA 23947 PROVIDER'S PLAN OF CORRECTION (X5) SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID COMPLÉTION (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) The DON or her designee will F 758 F 758 Continued From page 141 conduct a monthly review of This REQUIREMENT is not met as evidenced physician orders to identify by: Based on observation, clinical record review, GDRs and PRN medications staff interview, and facility document review, it within the facility. Residents was determined that the facility staff failed to identified in these categories ensure residents were free of unnecessary psychotropic medications for one of 6 residents in will be monitored by the the medication administration observation Cardinal IDT in its morning (Resident #44) and for two of 33 residents in the meetings to ensure survey sample; Residents #44, and #34. compliance with regulations. The Medical Director will 1. The facility staff failed to ensure adequate receive a report of the IDT indications prior to administering an as needed findings at the Monthly QAPI (prn) antipsychotic medication (Risperdal) to meeting and will make Resident #44. Staff administered the Risperdal to Resident #44 for complaints of anxiety, which suggestions as needed. was not a documented diagnosis for the administration of the medication and without attempting non-pharmacological interventions. 2. The facility staff failed to ensure adequate indications for the administration of as needed (PRN) Risperdal an antipsychotic medication and failed to administer the medication to Resident #44 per the physician's orders. 3. The facility staff failed to ensure targeted behaviors were identified, documented and monitored for the administration of the antipsychotic medication Seroquel to Resident #34. The findings include:

1. The facility staff failed to ensure adequate indications prior to administering an as needed (prn) antipsychotic medication (Risperdal) to

FINITED, UUI 10/2019

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495226	B. WING		C
	ROVIDER OR SUPPLIER D NURSING AND REHA		STF	REET ADDRESS, CITY, STATE, ZIP CODE LUNENBURG HIGHW YSVILLE, VA 23947	06/07/201 <u>9</u>
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 758	Resident #44. Staff Resident #44 for cor was not a document administration of the attempting non-phare Resident #44 was as 5/8/12 with the diaground severe major depressymptoms, demential disorder, anxiety dishigh blood pressure. The most recent MD significant change as (Assessment Referencesident was coded ability to make daily out of a possible 15 for Mental Status) expended for agitation is not an approved using most an approved using most an approved using most and administ to Resident #44: Zaditor (2) eye drops Miralax (3) 17 grams Voltaren gel (4), app Depakote (5) sprinkl 2 tabs (tablets) Calcium (6) 250mg, gave 1 tab	administered the Risperdal to implaints of anxiety, which ded diagnosis for the emedication and without imacological interventions. Idmitted to the facility on moses of but not limited to ssion with psychotic a with behavior, bipolar order, psychotic disorder, diabetes, and cataracts. It is a sessessment with an ARD ence Date) of 5/16/19. The as being cognitively intact in life decisions, scoring a 14 on the BIMS (Brief Interview kam. It is a life to the facility on moses of but not limited to ssion with psychotic disorder, diabetes, and cataracts. It is a sessessment with an ARD ence Date) of 5/16/19. The as being cognitively intact in life decisions, scoring a 14 on the BIMS (Brief Interview kam. It is a life to the Risperdal (1) bid (twice daily) prn (as n and bipolar. (Note: Anxiety use for Risperdal). If it is a life to the Risperdal (1) bid (twice daily) prn (as n and bipolar. (Note: Anxiety use for Risperdal). If it is a life to the facility on moses of the record revealed a steel of the record r	F 758		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

PRINTED: 06/18/2019 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

AND PLAN OF CORRECTION IDENT		IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED	
			n 37			С
		495226	B. WING		06/	07/2019
NAME OF P	ROVIDER OR SUPPLIER		Ε:	STREET ADDRESS, CITY, STATE, ZIP CODE		
WAYLAND	WAYLAND NURSING AND REHABILITATION CENTER			730 LUNENBURG HIGHW		
				KEYSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	appear anxious or aginer wheelchair and apwere no apparent sign LPN #1 did not offer a interventions at this til resident's Risperdal from the drawer. As she was president asked her whome in the resident to he with the resident to he medications. She assapplied the Voltaren gone then assisted the wheelchair, and admindrops and then gave to pills, including the Rismedications, LPN #1 medications, LPN #1	d Resident #44 if she on for anxiety." The d. The resident did not tated. The resident was in opeared very calm. There as of anxiety or agitation. any non-pharmacological me. She then took the om the medication cart oreparing the Risperdal, the tat it was. She stated to the anxiety. She then went or room to administer the sisted the resident up and tel to the resident's knees. resident back into the anistered the Zaditor eye the resident the cup of the perdal. After administering then assisted the resident to M, in an interview with LPN Risperdal isused for, LPN	F 758			
35	observation of the res as-needed (prn) antip the resident had reque anxiousness and had was tired, saying I car When asked if it was of stated it was. When a order stated it was for unable to show that the anxiety. When asked non-pharmacological	ident being offered an sychotic, LPN #1 stated that ested the Risperdal "for been yelling out, saying she of the stay up, and I gotta go." ordered for anxiety, LPN #1 asked to show where the anxiety, LPN #1 was are Risperdal was ordered for about offering interventions prior to lication, LPN #1 stated that				
		and bunched up and she				

(X2) MULTIPLE CONSTRUCTION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE COMP	SURVEY
	495226	B. WING			07/2019
NAME OF PROVIDER OR SUPPLIER WAYLAND NURSING AND REHA	BILITATION CENTER	1 7	TREET ADDRESS, CITY, STATE, ZIP CODE 30 LUNENBURG HIGHW (EYSVILLE, VA 23947		
PRÉFIX (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
informed of the obses showing any signs of medication cart at 8 the Risperdal without-pharmacological into that she had reposit time (in her room with Voltaren gel to her k (after administering of the issues the rest was tired. When it wand and not before, LPN asked for the medical have it. LPN #1 was staff follows for dete PRN (as needed) mustaff should try to fig wants the medication situation might be by pharmacological into medication only after ineffective. Further review of the reveal any nurses not of the resident's anx non-pharmacological review of the back of Administration Recoordinates and insistered for "rest anxiousness." On 6/06/19 at 7:11 F #4, she stated that F	adjusting her clothes. When ervation of the resident not of anxiety or agitation, at the 24 AM, and still being offered at offering non erventions. LPN #1 stated oned her clothes a second of the administration of the es) and assisted her to be all medications) because one ident expressed was that she was noted that these ons were done only in offer providing the medication, #1 stated the resident had ation and it was her right to a saked about the process the rmining if a resident needs a redication. LPN #1 stated that the ure out why the resident not offering non erventions, and give the rother attempts are a clinical record failed to offer documenting the nature rety and agitation or any I interventions attempted. A fine MAR (Medication red) for June 2019 for red the Risperdal was	F 758			

	D HUMAN SERVICES			FORM APPROVE
CENTERS FOR MEDICARE & N STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED
THE TENTO CONTENT OF	DENTIFICATION NUMBER.	A. BUILDING_		C
	495226	B. WING		06/07/2019
NAME OF PROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	-
WAYLAND NURSING AND REHABII	LITATION CENTER		30 LUNENBURG HIGHW (EYSVILLE, VA 23947	
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 758 Continued From page	145	F 758		
is not used for anxiety. not give a resident Ris anxiety. She stated the need to be combative of exhibiting some type of stated she would not go not showing these symmathe care plan was not for the care plan was not for the care plan was given for the probability probability protocol and the probability protocol and the care plan was given for the probability protocol and the care plan was given for the probability protocol and	She stated that she would perdal if they say they have at to give it, there would or aggressive behaviors or f psychotic behaviors. She live it if the resident were aptoms. She stated that followed because the or the wrong reason. The wrong reason. She stated that followed because the or the wrong reason. Shensive care plan lematic manner in which rized by ineffective coping: sison or Combativeness apairments/phys (physical). This care plan was dated ons included one dated document behavior per ne dated 5/31/18 for "Give ed by MD (medical doctor); for "Document episodes of locol and notify MD of ln addition, a care plan ted, "Use of psychotropic l for or characterized by of medications, sychotic." This care plan tention dated 6/5/12 for its per physician's order."			

resident receiving such drugs for possible adverse consequences and to measure progress in achieving therapeutic objectives. 3. To encourage the use of non-drug interventions prior

to and, if indicated, in conjunction with

	AND BLAN OF CORRECTION		E CONSTRUCTION	(X3) DATE	SURVEY	
						С
NAME OF B	DOMBER OF SURPLIES	495226	B. WING		06/	07/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW		
WAYLAND	NURSING AND REHAB	ILITATION CENTER	- I	KEYSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 758	Continued From page	146	F 758			
	antipsychotic drug the other pharmacologica possible"	rapy as well as the use of I interventions when				
	Staff Member - the Ad Director of Nursing) a Consultant) were notif	, ASM #1 (Administrative Iministrator), ASM #2 (the nd ASM #4 (Facility Nurse fied of the concerns. No s provided by the end of the				8
	treat schizophrenia, m episodes, and behavio Information obtained f	ors.				
	(2) Zaditor - is an opth relieve the itching of a Information obtained f https://medlineplus.go tml	llergic pinkeye.				
	(3) Miralax - is used to Information obtained f https://medlineplus.go tml	,	*:			
	from osteoarthritis. Information obtained f	cal gel used to treat pain rom v/druginfo/meds/a611002.ht				
	(5) Depakote - is used bipolar disorder. Information obtained f https://medlineplus.go					

	F CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	405000			C
NAME OF P	495226 ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE	06/07/201 <u>9</u>
WAYLANI	NURSING AND REHABILITATION CENTER		30 LUNENBURG HIGHW KEYSVILLE, VA 23947	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION
F 758	Continued From page 147 tml (6) Calcium - Calcium is a mineral found in many foods. The body needs calcium to maintain strong bones and to carry out many important functions. Almost all calcium is stored in bones and teeth, where it supports their structure and hardness. The body also needs calcium for muscles to move and for nerves to carry messages between the brain and every body part. In addition, calcium is used to help blood vessels move blood throughout the body and to help release hormones and enzymes that affect almost every function in the human body. Information obtained from https://ods.od.nih.gov/factsheets/Calcium-Consumer/ 2. The facility staff failed to ensure adequate indications for the administration of as needed (PRN) Risperdal an antipsychotic medication and failed to administer the medication to Resident #44 per the physician's orders. Resident #44 was admitted to the facility on 5/8/12 with a recent readmission on 5/9/19 with diagnoses that included but were not limited to: depression, diabetes, dementia, bipolar disorder [a mental disorder characterized by episodes of mania and depression (1)], anxiety disorder, high blood pressure and osteoarthritis [characterized by degenerative changes in the joints, pain,	F 758		
	stiffness and swelling can develop after exercise (2)]. The most recent MDS (minimum data set) assessment, a significant change assessment, with an assessment reference date of 5/16/19, coded the resident as scoring a "14" on the BIMS (brief interview for mental status) score, indicating			

	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED
1		495226	B. WING		C 06/07/2019
	ROVIDER OR SUPPLIER D NURSING AND REHAB		STRI 730	EET ADDRESS, CITY, STATE, ZIP CODE LUNENBURG HIGHW 'SVILLE, VA 23947	00/07/201 <u>8</u>
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLÉTION
F 758	the resident was capa cognitive decisions. requiring extensive as member for most of h Section N - Medicatio as having received ar on four days during the period. The physician order of "Risperdal [used to trobipolar disease (3)], to po (by mouth) BID (two for agitation." The nurse practitioned documented in part, "was changed from two basis to twice a day at the continued use of a medication by the attenurse practitioner. As 6/7/19, 23 days after the continued use of a medication by the attenurse practitioner. As 6/7/19, 23 days after found evidencing the of Risperdal. The May 2019 MAR (record) documented to The medication was considered to the medication of the administration of the adminis	able of making daily The resident was coded as asistance of one staff or activities of daily living. In ans, the resident was coded an antipsychotic medication are last seven-day look back of the last seven-day look back look ba	F 758		

FORM APPROVED OMB NO. 0938-0391

	CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED
				С
	495226 ROVIDER OR SUPPLIER D NURSING AND REHABILITATION CENTER	B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947		06/07/201 <u>9</u>
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 758	Continued From page 149 physicians order. The medication was documented as given on 6/3/19 at 6:00 p.m. and 6/4/19 at 6:30 a.m. for "anxiety." Review of the nurse's notes for the above dates failed to evidence any documentation on 6/3/19 and 6/4/19 related to the administration of the above medication.	F 758		
	The comprehensive care plan dated, 2/8/18, documented in part, "Focus: Problematic manner in which resident acts characterized by ineffective coping; verbal/physical aggression or combativeness related to: cognitive impairment/physical changes in brain." The "Interventions" documented in part, "Monitor and document behavior per facility protocol." The care plan dated, 5/31/18, further documented, "Focus: Problematic manner in which resident acts characterized by ineffective coping; Agitation/Combativeness related to: Drug side effects, frustration." The "Interventions" documented in part, "Give medication as prescribed by MD (medical doctor). Monitor and document behaviors per facility protocol.			
	An interview was conducted with ASM (administrative staff member) # 3, the assistant director of nursing, on 6/6/19 at 11:20 a.m. When asked if Risperdal can administered as needed (PRN), ASM #3 stated, "It's dictated by the order." The order above for agitation was reviewed with ASM #3. When asked if Risperdal could be administered for anxiety, ASM #3 stated, "I don't think so." When asked how often are PRN antipsychotic medications are renewed, ASM #3 stated, "It's based on what (name of nurse practitioner) wants us to do." ASM #3 was asked if an as needed antipsychotic medication is reviewed periodically to evaluate to need for			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
	,	495226	B. WING			07/2019
	ROVIDER OR SUPPLIER NURSING AND REHAB		s 7	TREET ADDRESS, CITY, STATE, ZIP CODE 30 LUNENBURG HIGHW (EYSVILLE, VA 23947	00/	07/2019
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 758	reviews the medication recommendations on asked if she was awa regarding the use of F	#3 stated, "The pharmacist ins and makes a monthly basis." When re of the regulation	F 758			
	director of nursing; on #2 was asked to revie asked the nurses give for anxiety when the c ASM #2 stated, "Anxie agitation." ASM #2 stated practitioners don't like medications around. I who was just readmitt after a psychiatric adm 4/11/19, has been see services, ASM #2 state that. On 6/6/19 at app	When asked if the resident, and on 5/9/19, to the facility mission to the hospital on the properties of the facility psychiatric and she's have to look into proximately 4:45 p.m., ASM chiatric consults. The last	=			
	facility nurse consulta When asked if there a for the use of a PRN a ASM #4 stated, "They day and have to be re	ducted with ASM #4, the nt, on 6/7/19 at 7:52 a.m. are any special requirements antipsychotic medication, are can only be written for 14 evaluated and has to be norough evaluation by the				
	member (OSM) #7, the consultant, on 6/7/19 PRN (as needed) anti	ducted with other staff he facility pharmacy at 9:32 a.m. When asked if hesychotics are allowed to DSM #7 stated, "There is a				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED		
		495226	B. WING_				07/2019
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		-
WAYLAND	NURSING AND REHABI	ILITATION CENTER	i		0 LUNENBURG HIGHW		_
				KE	EYSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 758	Continued From page	151	F 7	758			
	14 days they have to	y can be used but after that be reevaluated by the entation of their continued					
	failed to evidence doc	ntipsychotic Drug Therapy" sumentation related to the otic medications and their	2)				
	ASM #1, the administration of nursing, and ASM # consultant, were made findings on 6/6/19 at 7	e aware of the above	Ñŧ.				
	No further information	was provided prior to exit.			15		
-	Non-Medical Reader, Chapman, page 72. (2) Barron's Dictionan Non-Medical Reader, Chapman, page 422. (3) This information w following website:	y of Medical Terms for the 5th edition, Rothenberg and y of Medical Terms for the 5th edition, Rothenberg and as obtained from the ov/druginfo/meds/a694015.h					
	3. The facility staff fail behaviors were identifumonitored for the admantipsychotic medicat #34.	fied, documented and			5		
K	Resident #34 was adr 10/17/17 with diagnos	mitted to the facility on ses that included but were					

C 495226 NAME OF PROVIDER OR SUPPLIER WAYLAND NURSING AND REHABILITATION CENTER C 06/07/2019 T30 LUNENBURG HIGHW		F CORRECTION	IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	COMPLETED
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW						
KEYSVILLE, VA 23947	NAME OF PROVIDER OR SUPPLIER			st 1 73	TREET ADDRESS, CITY, STATE, ZIP CODE	06/07/201 <u>9</u>
	PREFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE COMPLETION
F 758 Continued From page 152 not limited to: diabetes, dementia, depression, stroke, high blood pressure, and bradycardia (A slow heart beat lower than 60 in adults) (1). The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 5/10/19, coded the resident as scoring "3" on the BIMS (brief interview for mental status) score, indicating the resident was severely impaired to make daily cognitive decisions. In Section E - Behaviors, the resident was severely impaired to make daily cognitive decisions. In Section E - Behaviors, the resident was not coded as having any behaviors during the look back period and as not having indicators of psychosis. The MDS assessment, a quarterly assessment, with an assessment, a quarterly assessment, with an assessment reference date of 2/28/19, in Section E - Behaviors, did not code the resident as having any behaviors during the look back period and as not having indicators of psychosis. The MDS assessment, a quarterly assessment, with an assessment reference date of 11/29/18, documented in Section E - Behaviors, did not code the resident as having any behaviors during the look back period and as not having indicators of psychosis. The MDS assessment, an annual assessment, with an assessment reference date of 8/31/18, documented in Section E - Behaviors, did not code the resident as having any behaviors during the look back period and as not having indicators of psychosis. The physician order dated, 8/20/18, documented, "Sercquel (Quetlapine-generic) [used to treat schizophrenia and along with other medications, depression (2)] lab (tablet) 25 mg (milligrams) 1/2	F 758	not limited to: diabete stroke, high blood preslow heart beat lower. The most recent MD assessment, a quarte assessment reference resident as scoring interview for mental stresident was severel cognitive decisions. It resident was not code during the look back indicators of psychostic modern as having any behave period and as not has the look back period of psychosis. The MDS assessment documented in Section E - Behavior as having any behave period and as not has the look back period of psychosis. The MDS assessment documented in Section E - Behavior as the look back period of psychosis. The MDS assessment documented in Section E - Behavior as the look back period of psychosis. The MDS assessment documented in Section E - Behavior as the look back period of psychosis.	es, dementia, depression, essure, and bradycardia (A r than 60 in adults) (1). S (minimum data set) erly assessment, with an ce date of 5/10/19, coded the 3" on the BIMS (brief status) score, indicating the y impaired to make daily in Section E - Behaviors, the led as having any behaviors period and as not having sis. Int, a quarterly assessment, reference date of 2/28/19, in s, did not code the resident fiors during the look back ving indicators of psychosis. Int, a quarterly assessment, reference date of 11/29/18, on E - Behaviors, did not having any behaviors during and as not having indicators Int, an annual assessment, reference date of 8/31/18, on E - Behaviors, did not having any behaviors during and as not having indicators dated, 8/20/18, documented, ne -generic) [used to treat long with other medications,	F 758		

PRINTED: 06/18/2019 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING_ C B. WING 495226 06/07/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW WAYLAND NURSING AND REHABILITATION CENTER KEYSVILLE, VA 23947 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION **PREFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) Continued From page 153 F 758 = 12.5 mg by mouth every night at bedtime for depression/insomnia." A review of the May and June 2019 MAR (medication administration record) documented the above physician medication order and documented the medication was administered every day as ordered. A review of the nurse's notes from 12/1/19 through 6/6/19 documented the following behaviors: "1/25/19 at 2:40 p.m. - message left for RR (resident representative) regarding condition of resident's feet. Ares remain dry continuing with the cream however, he frequently refused to allow it to be put on. "2/2/19 at 10:45 p.m., Resident has short term memory loss. Wants to go to bed as soon as he eats supper. Staff has to remind him every night that we are in the middle of supper and feeding other residents. Resident will say OK, then a few minutes later will be calling for help. Is saying he wants to go to bed. Wife brings him snack food and drinks from home, which he eats before supper. "2/13/19 at 2:51 p.m. Nurse called and spoke with RR about resident refusal with shaving. She

refusal of shower.

refuse.

facility, use what is here.

stated that she had already brought razor up to

"2/26/19 at 11:52 a.m. Resident flagging x 3days no BM (bowel movement). Nurse attempted to administer MOM (milk of magnesia) and resident stated, 'I'm not taking that.' Resident continues to

"3/6/19 at 2:38 p.m. RR aware about refusal of taking MOM x3 day d/t (due to) no BM and

"3/7/19 at 6:20 a.m. Per CNA (certified nursing

	CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COMPLETED
NAME OF S	495226	B. WING	**************************************	C 06/07/201 <u>9</u>
	ROVIDER OR SUPPLIER NURSING AND REHABILITATION CENTER	1 73	TREET ADDRESS, CITY, STATE, ZIP CODE 30 LUNENBURG HIGHW EYSVILLE, VA 23947	2
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLÉTION
	Continued From page 154 assistant) resident refused to be shaved this morning, writer offered to so still resident refused. "3/15/19 at 10:06 a.m. Flagging x3 days no BM. nurse attempted to administer MOM and resident refused. "3/30/19 at 8:41 a.m., Resident refused shower. "4/8/19 at 12:02 p.m. resident flagging for no BM x 3 days, would only accept half (15 ml [milliliters]) of MOM of 30 ml (milliliter) dose. "4/8/19 at 7:00 p.m. REFUSAL - resident refused to be lifted by CNA w/lift (with lift) under direct supervision. "4/18/19 at 2:08 p.m. resident flagging for no BM x 3 days, resident only accepted 15 cc (cubic centimeters) MOM. "4/22/19 at 11:08 a.m., Resident flagging for no BM x3 days, resident refused to take MOM per protocol. "4/24/19 at 5:52 a.m. Resident flagging for no bowel movement in the past three days. Due to refusal of MOM. "5/15/19 at 5:51 a.m. Resident flagging for no BM x3 days, MOM refused. "5/17/19 at 10:29 a.m. Resident flagging for no BM x 3 days. MOM given but resident would only take apprx (approximately) 15 cc [cubic centimeter]. The physician notes dated 11/26/18, documented in part, "Psych (psychiatric): he is pleasant and understand who I am as the doctor. No other documentation regarding his mood or behaviors. The physician note dated, 12/3/18, failed to evidence documentation related to mood or behaviors.	F 758		
	The physician note dated, 4/1/19, failed to			

PRINTED: 06/18/2019 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING C 495226 B. WING 06/07/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW WAYLAND NURSING AND REHABILITATION CENTER KEYSVILLE, VA 23947 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 758 Continued From page 155 F 758 evidence any documentation related to mood or behaviors. The nurse practitioner note dated, 12/5/18. documented in part, "Past Medical History depression. Review of Systems: Psychiatric - no increased nervousness or suicidal ideations. Physical Exam: Psychiatric: no increased nervousness or suicidal ideations. The nurse practitioner note dated, 2/22/19, documented in part, "Past Medical History depression. Review of Systems: Psychiatric - no mood swings, increased nervousness or suicidal ideations. Physical Exam: Psychiatric - Mood and affect pleasant, resident oriented to person and place. The nurse practitioner note dated, 5/30/19 documented in part, "His nurse reports resident compliance with his medication and diet (Resident #34) has depression. His nurse reports

irritability, mood swings and decreased

oriented to person and place.

motivation. She reports he is compliant with his medication and cooperative with his care. He denies any suicidal ideations or homicidal ideations...Past Medical History - Depression. Review of Systems: Psychiatric: no changes in cognition or increased nervousness...Physical Exam: Psychiatric: Mood and affect flat; resident

The comprehensive care plan dated, 10/22/18 documented in part, "Focus: Problematic manner in which resident acts characterized by ineffective

"Interventions" documented in part, "Monitor and document behavior (physical) behaviors) per

coping; verbal/physical aggression or combativeness related to: anger." The

	F CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED
	495226	B. WING		C
NAME OF PROVIDER OR SUPPLIER WAYLAND NURSING AND REHABILITATION CENTER		STR 730	REET ADDRESS, CITY, STATE, ZIP CODE LUNENBURG HIGHW YSVILLE, VA 23947	06/07/201 <u>9</u>
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 758	Continued From page 156 facility protocol." The care plan further documented, "Focus: Problematic manner in which resident acts characterized by ineffective coping; Sleeplessness/insomnia related to: restlessness." The "Interventions" documented in part, "Administer medication. Monitor sleep pattern and quality of sleep/rest, document episodes, and notify physician of changes for possible interventions as appropriate." The care plan documented "Focus: Use of psychoactive drugs with the POTENTIAL FOR or characterized by SIDE EFFECTS of cardiac, neuromuscular, gastrointestinal systems AEB (as exhibited by) or/due to diagnoses of: antipsychotic, antidepressant (GDR [gradual dose reduction] antipsychotic 7/6/18." The "Interventions" documented, "Administer medications per physician's orders. Observe resident's mental status functioning on ongoing basis." An interview was conducted with LPN (Licensed practical nurse) #2 on 6/5/19 at 5:43 p.m. When asked where behaviors are documented, LPN #2 stated, on the back of the MAR (medication administration record) and in the progress notes." LPN #2 was asked what Resident #34's targeted behaviors are for the use of Seroquel. LPN #2 stated, "When he first came he was on it but it's been cut back. His wife said he took it at home to help him sleep. Lately his behaviors are much improved." When asked when she would document a behavior, LPN #2 stated she's document it if she saw the resident having a behavior or something that is out of their norm." An interview was conducted with RN (registered nurse) #2, on 6/5/19 at 5:45 p.m. When asked where behaviors are documented, RN #2 stated in the computer under behavior notes. When	F 758		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION

AND DUAN OF CODDECTION IDENTIFICATION AND DED		(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					С
		495226	B. WING)	06/07/2019
NAME OF P	ROVIDER OR SUPPLIER		ST	FREET ADDRESS, CITY, STATE, ZIP CODE	-
WAYLAND	NURSING AND REHAE	BILITATION CENTER	73	0 LUNENBURG HIGHW	
	P:	THE THE TENT	K	EYSVILLE, VA 23947	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COR	
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	
F 758	Continued From pag		F 758		
		ted behaviors for Resident f Seroquel, RN #2 stated, "I			
	nursing, on 6/5/19 at about the process for resident behaviors, A be in the progress no behavior." ASM #2 w #34's targeted behav	nducted with ASM nember) #2, the director of 5:47 p.m. When asked documenting targeted SM #2 stated, "They should tes under health status or as asked what Resident iors are for the use of ated she would have to			
	ASM #5, the nurse pra.m. When asked the on Seroquel, ASM # and depression." Who clinical record docum depression/insomnia. resident has been masince admission. (10/insomnia is an indicastated, "No, it's not." #34's behaviors are fa ASM #5 stated, "He he behaviors. When ask behaviors are as the failed to evidence document for refusing M #5 stated, "I talk to the tell me his behaviors. When ask documentation." When psychiatric services a #5 stated, "Yes, but it not satisfied with the	ed what the targeted review of the clinical record cumentation of behaviors, OM and to be shaved, ASM e nurse and CNAs and they			

		DENTIFICATION NUMBER:		E CONSTRUCTION	COMPLETED
		40-00	B. 1401.0		С
NAME OF PROVIDER OR SUPPLIER WAYLAND NURSING AND REHABILITATION CENTER		B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947		06/07/201 <u>9</u>	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	ENT OF DEFICIENCIES T BE PRECEDED BY FULL ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLÉTION
F 758	Continued From page 158 nurse practitioner. Transport the resident to an outs going to look into getting of services once the survey if a GDR (gradual dose reduct attempted, as the resident documented behaviors and Seroquel, ASM #5 stated, attempted but my experier resident either have to be behaviors return and increed. An interview was conducted director of nursing; on 6/6/#2 was asked if the psychical Resident #34. ASM #2 stated When asked why Resident ASM #2 stated, "He first cangry, mad and came from doctors and nurse practition change things. He was king staff." ASM #2 stated she had no notes from this resident. She president will place him on some Set probably help with his insomallucinations." Review of the clinical reconstruction of Resexhibiting hallucinations. ASM #1, the administrator of nursing, and ASM #4, the consultant were made award concern on 6/6/19 at 7:35	ortation is an issue to ide psychiatrist. We are ther psych (psychiatric) is over." When asked if ction) should be does not have d is on a low dose of "I guess it can be ace with GDR is that the hospitalized or their ase." It with ASM #2, the 19 at 11:37 a.m., ASM atrist had seen ted, "I don't think so." at #34 was on Seroquel, ame here he was very in the hospital with it. My mer are hesitant to king and cursing at would check on then returned and om psychiatric services ented an admission 10/13/17, that sessment/Plan: We roquel. That will minia and ASM #2, the director e facility nurse are of the above	F 758		

FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
	· ·			-	. (
		495226	B. WING		06/	07/2019
NAME OF P	ROVIDER OR SUPPLIER		;	STREET ADDRESS, CITY, STATE, ZIP CODE	61	
WAVE A NE	NURSING AND REHABI	LITATION CENTER	î i	730 LUNENBURG HIGHW		
WAILAND	NORSING AND KENABI	LITATION CENTER		KEYSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 758	Continued From page		F 758			
F 880 SS=F	(1) Barron's Dictionary Non-Medical Reader, Chapman, page 87. (2) This information we following website: https://medlineplus.gotml. Infection Prevention & CFR(s): 483.80(a)(1)(s) §483.80 Infection Con The facility must establing infection prevention and designed to provide a comfortable environmed evelopment and trandiseases and infection §483.80(a) Infection program. The facility must establiand control program (I a minimum, the following \$483.80(a)(1) A system reporting, investigating and communicable disstaff, volunteers, visito providing services under the system of	v/druginfo/meds/a698019.h Control 2)(4)(e)(f) Itrol Dish and maintain an and control program safe, sanitary and ent and to help prevent the smission of communicable as. revention and control Dish an infection prevention PCP) that must include, at ing elements: m for preventing, identifying, and controlling infections seases for all residents, ars, and other individuals ler a contractual	F 880			
	conducted according t accepted national star	oon the facility assessment o §483.70(e) and following ndards; standards, policies, and				

		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 06/18/2019 FORM APPROVED OMB NO. 0938-0391
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
7.5					С
		495226	B. WING		06/07/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
MANA AND	AUTOCING AND DELLAD	II ITATION CENTER	î	730 LUNENBURG HIGHW	
VVATLANL	NURSING AND REHAB	ILITATION CENTER		KEYSVILLE, VA 23947	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION
F 880	Continued From page	e 160	F 88	F-880	
	procedures for the probut are not limited to: (i) A system of surveil possible communication infections before they persons in the facility (ii) When and to whor communicable disease reported; (iii) Standard and tranto be followed to prev (iv) When and how is cresident; including but (A) The type and durations.	ogram, which must include, llance designed to identify ble diseases or can spread to other mathematical process of the can be considered as a	5	The maintenance person have received further training or the facility's legionella program. Areas subject to infection will be identified awater testing logs will be maintained. Infection contlogs will be updated. Staff will receive in service education on the facility's Infection Control program.	and rol
	involved, and (B) A requirement that least restrictive possilicircumstances. (v) The circumstance must prohibit employed disease or infected significant with residents contact will transmit to (vi)The hand hyglene by staff involved in displacements.	procedures to be followed rect resident contact.	34	the requirements thereof. individual RN will be secure to administer the program. Maintenance testing logs for the Legionella program will maintained in the maintenance office and reported to the Safety Committee monthly. Infectional logs will be maintained in the SDC/IC	An ed or I be

infection.

§483.80(e) Linens.

§483.80(f) Annual review.

corrective actions taken by the facility.

Personnel must handle, store, process, and

transport linens so as to prevent the spread of

The facility will conduct an annual review of its

office and presented each month to the QA Committee.

The QAPI Committee will

receive reports from the

and review.

Safety Committee and the IC

Nurse to provide oversight

FORM APPROVED OMB NO. 0938-0391

	F CORRECTION (X1) PROVIDER/SUPPLIER/CLIA	A. BUILDING		COMPLETED
	495226	B. WING		C 06/07/2019
	ROVIDER OR SUPPLIER D NURSING AND REHABILITATION CENTER	STR 730	EET ADDRESS, CITY, STATE, ZIP CODE LUNENBURG HIGHW (SVILLE, VA 23947	06/07/201 <u>9</u>
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLÉTION
F 880	Continued From page 161 IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined the facility staff failed to have a Legionella policy and a complete infection control program, as evidenced by a lack of infections control tracking logs for the months of April 2019 through May 2019, and incomplete tracking logs for the months of December through March 2019; and failed to follow infection control practices during medication administration for one of six residents in the medication administration observation, Resident #41. The facility staff touched a pill with their bare hands and then administered the medication to Resident #41.	F 880		
	The findings include: 1. On 6/4/19 at approximately 12:15 p.m., upon entrance to the facility a copy of the policy and procedure for the water management to reduce the risk of growth and spread of Legionella and other opportunistic pathogens in the facility water systems, was requested. On 6/6/19 at 2:32 p.m. Administrative staff member (ASM) #1, the administrator, presented a packet of papers entitled, "Developing a Water Management Program to Reduce Legionella Growth and Spread in Buildings." When asked if this was their policy, ASM #1 informed the survey team that he has been through three different maintenance men in the past year. His current maintenance director has only been in the building for three week and is learning all of the things that are to be done is his department. The			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE	(X3) DATE SURVEY COMPLETED	
	ROVIDER OR SUPPLIER	495226	730	EET ADDRESS, CITY, STATE, ZIP CODE LUNENBURG HIGHW YSVILLE, VA 23947	06	C /07/201 <u>9</u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 880	corporate office is wo getting the Legionella building. On 6/6/19 at 3:32 p.r survey team and stat the maintenance depany documentation reany testing that has been to locate what areas a Legionella program.	orking on training him and a program into effect in the n., ASM #1 returned to the ed he has looked through artment and cannot locate egarding the program and been completed. He could a that would be of concern in	F 880	- 12			
	made aware of the al 7:35 p.m. No further information 2. The facility staff facontrol tracking logs through May 2019 ar logs for the months of 2019. On 6/4/19 at approximation entrance conference Administrator (ASM # Member) and ASM # The infection control months was requested. The information provinfection Control Replace in the infection of the infection of the infections at the infection of the infections at the infection of the infection of the infections at the infection of the infections at the infection of the infections at the infection of the infecti	n was provided prior to exit. It was provided prior to exit.			05		

FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:	A. BUILDING		OMPLETED
			С
NAME OF PROVIDER OR SUPPLIER WAYLAND NURSING AND REHABILITATION CENTER	STREET ADDRE	SS, CITY, STATE, ZIP CODE	06/07/201 <u>9</u>
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)	PREFIX (EA	PROVIDER'S PLAN OF CORRECTION ACH CORRECTIVE ACTION SHOULD BE SS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
Director of Nursing) and ASM #4 (Facility Nurse Consultant) were notified of the concerns that there appeared to be no infection control tracking provided. On 6/7/19 at 8:46 AM, ASM #3 (the Assistant Director of Nursing) provided the line-item tracking logs from December 2018 through March 2019. There was no evidence of any infections that were not treated with an antibiotic being tracked. There were no logs for April 2019 and May 2019 provided. ASM #3 stated that she "created the logs last night" based on data left by the former infection control nurse, who was no longer at the facility, but that there was no data to create the logs for April 2019 and May 2019, after the former infection control nurse had left. A review of the facility policy, "Infection Prevention and Control Program (IPCP)" documented, "The objectives of this IPCP are to: "Establish system for the prevention, identification, investigation, and control of infection of residents, staff, and visitors." No further information was provided by the end of the survey. 3. The facility staff touched a pill with their bare hands and then administered the medication to Resident #41. Resident #41 was admitted to the facility on 7/10/18 with the diagnoses of but not limited to acute respiratory failure, diabetes, high blood pressure, anxiety disorder, breast cancer, bladder disorder, atrial fibrillation, congestive heart failure, chronic obstructive pulmonary disease,	F 880		

	F CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED	
	495226	B. WING		C	
	PROVIDER OR SUPPLIER D NURSING AND REHABILITATION CENTER	STR	EET ADDRESS, CITY, STATE, ZIP CODE LUNENBURG HIGHW 'SVILLE, VA 23947	06/07/201 <u>9</u>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
F 880	Continued From page 164 MDS (Minimum Data Set) was a significant change assessment with an ARD (Assessment Reference Date) of 5/3/19. The resident was coded as being moderately impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing; extensive care for transfers, dressing, toileting, and hygiene; supervision for eating; and was usually continent of bowel and bladder. On 6/04/19 at 4:34 PM, LPN #2 was observed to prepare and administer the following medications to Resident #41: Lopressor (1) 12.5 mg (milligrams) (1/2 of a 25 mg tablet) Calcium (2) 500 mg, 1 tablet Megace (3) 20 mg, 1 tablet Muro (4) 128 solution, left eye, 1 drop While preparing the Calcium, LPN #2 popped, the tablet into the medication cup then picked it up with her bare fingers and placed the pill into the pill cutter, cut the pill in half, and placed it into the medication cup. She also did not sanitize the pill cutter before or after using it. 06/05/19, 05:49 PM, in an interview with LPN #2, she stated, "I handled the pill with my hand. I should have put gloves on." When asked if she realized at the time that she had done that, LPN #2 stated she did but "I thought silence is golden." When asked what she should have done, LPN #2 stated that she should have discarded it, put gloves on and poured another one. On 6/6/19 at 7:43 PM, ASM #1 (Administrative Staff Member - the Administrator), ASM #2 (the Director of Nursing) and ASM #4 (Facility Nurse Consultant) were made aware of the findings. No	F 880			

PRINTED: 06/18/2019 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING C 495226 B. WING 06/07/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW WAYLAND NURSING AND REHABILITATION CENTER KEYSVILLE, VA 23947 SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 880 Continued From page 165 F 880 further information was provided by the end of the survey. (1) Lopressor - used to treat high blood pressure. Information obtained from https://medlineplus.gov/druginfo/meds/a682864.h tml (2) Calcium - Calcium is a mineral found in many foods. The body needs calcium to maintain strong bones and to carry out many important functions. Almost all calcium is stored in bones and teeth, where it supports their structure and hardness. The body also needs calcium for muscles to move and for nerves to carry messages between the brain and every body part. In addition, calcium is used to help blood vessels move blood throughout the body and to

help release hormones and enzymes that affect almost every function in the human body.

https://ods.od.nih.gov/factsheets/Calcium-Consu

https://medlineplus.gov/druginfo/meds/a682003.h

http://www.bausch.com/our-products/dry-eye-products/corneal-edema/muro-128-ointment

Required In-Service Training for Nurse Aides

(3) Megace - used to treat loss of appetite, malnutrition, and severe weight loss.

(4) Muro - used to treat corneal edema.

Information obtained from

Information obtained from

Information obtained from

CFR(s): 483.95(g)(1)-(4)

mer/

tml

F 947

SS=C

F 947

		PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER:		E CONSTRUCTION	COMPLETED
		495226	B. WING		C 06/07/2019
	ROVIDER OR SUPPLIER D NURSING AND REHABILITA	TION CENTER	1.7	STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947	00/07/201 <u>3</u>
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	ENT OF DEFICIENCIES IT BE PRECEDED BY FULL ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
F 947	Continued From page 166 §483.95(g) Required in-services aides. In-service training must- §483.95(g)(1) Be sufficient continuing competence of the no less than 12 hours in §483.95(g)(2) Include dent training and resident abust sufficient abust sufficient and facility assessment at address the special needs and facility assessment at address the special needs determined by the facility sufficient abust sufficient	t to ensure the nurse aides, but must per year. It to ensure the nurse aides, but must per year. It to ensure the nurse aides, but must per year. It to ensure the nurse aides, but must per year. It to ensure the nurse aides, but must per year. It to ensure the nurse aides, but must per year. It to ensure the nurse aides, but must per year. It to ensure the nursing as a performance reviews \$ 483.70(e) and may of residents as a performance reviews \$ 483.70(e) and may of	F 947		

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				OMB N	10. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		TE SURVEY MPLETEQ
	100	495226	B. WING			0	C 6/07/2019
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		3-29-00-0-10-0-19-0-19-0-19-0-19-0-19-0-1
				73	0 LUNENBURG HIGHW		
WAYLANI	O NURSING AND REH	ABILITATION CENTER		KE	EYSVILLE, VA 23947		
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F 947	Cantinuad From po	ogo 167	_	947			
Г 947	Continued From pa	ige 167		947	F-947		
	member.						
	A	of what was a selected from the			A Staff Development Nurs		
		of nine was selected from the			has been hired by the faci	lity	
		nnual 12 hours of training was me for the three CNAs.			to conduct required in ser	vice	
	requested at this th	THE TOT THE THEE CIVAS.			training for Nurses' Aides.		
	The hire dates of the						
	CNA #3 - 5/16/13			CNAs who are currently			
	CNA #4 - 2/6/91				lacking annual documenta	ation	
	CNA #5 - 11/16/96				of required training will be	е	
	0 0540 1140	4014 () 1 1 1 1 1 1 1 1 1 1			targeted to gain complian		
	On 6/5/19 at 4:13 p.m. ASM (administrative staff member) #1, the administration provided training				targeted to gain compilar	001	
		ere were two educations			The Staff Development an	ıd	
		evention policy and reporting.			training program will be		
		nly one that received this			0, 0	la a u	
		was asked to present the			supervised by the DON or		
	1	he 12 hours of training for the			Designee and Administrat	ion.	
		ASM #1 stated they do not			S E D CH LAND		
		tation of the 12 hours of			Results of the annual train	iing	
	training for any of t	he CNAs that have been			and compliance will be		
	employed greater t	han one year. They do not			reported to the facility's C	LAPI	
		opment staff member at this			Committee for oversight a	and "	
		ne through the previous			continued compliance.		
		and could not locate the			continued compilative.		
	twelve hours.						1,10
							17/21117
		'In-service policy" documented					1/0.11
		In-service Programs: Monthly predetermined to meet the			895		
		, ill and disabled resident will					
	_	ersonnel will be encouraged to					
		records at in service meetings					
		meeting will be kept.					
		e records will be kept on all					
		ng assistants are required to					
		ve (12) hours per anniversary					
		responsibility of the SDC (staff					
		linator)/designee to offer			**		

DEPARTMENT OF HEALTH AND HUMAN SERVICES

FORM APPROVED

	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	CONSTRUCTION	COMPLETED
		495226	B. WING		C
	ROVIDER OR SUPPLIER D NURSING AND REHAE		STF 730	REET ADDRESS, CITY, STATE, ZIP CODE LUNENBURG HIGHW YSVILLE, VA 23947	06/07/201 <u>9</u>
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F 947	in-services during all convenience in comp requirements. Facility accumulated per qua order to keep facility requirements. D. Mar Accidents/safety/haza advanced directives, pathogens/exposure AIDS, combative resi corporate compliance use of gait belt, denta disaster preparednes Procedures - Code." ASM #1, the administ of nursing, and ASM consultant, were mad findings on 6/6/19 at 1	three shifts for staff liance with twelve (12) hour les will post in-service hours rer for nursing assistants in and staff current with the adatory In-services: ard communications, bloodbourne control plan/HVB, HIV and dents, confidentiality, employee packet, correct I, dementia management, s, and emergency rator, ASM #2, the director #4, the facility nurse e aware of the above	F 947		